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

March 27, 2015

Mr. Stephen Fitton
State Medicaid Director
Medical Services Administration
Michigan Department of Community Health
400 South Pine Street
Lansing, MI 48933

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) approves Michigan's §1915(c) home and community-based services (HCBS) waiver amendment to the Waiver for Children with Serious Emotional Disturbances, CMS control number 0438.R02.01. Effective April 1, 2015, this amendment changes the rate methodology in the waiver to align with the methodology found in Michigan's §1915(c) Children's Waiver Program. The waiver amendment also includes a Home and Community-Based Settings Transition Plan, in accordance with the HCBS final regulation published on January 16, 2014, and updates the waiver eligibility section of the application to comply with Section 2404 of the Affordable Care Act as it relates to spousal impoverishment protections for individuals with a community spouse. The amendment did not affect cost-neutrality of the waiver.

The CMS would greatly appreciate ongoing communication with the state to help keep the Regional Office informed of any changes or updates related to this waiver. If there are any questions please contact Eowyn Ford at (312) 886-1684 or Eowyn.Ford@cms.hhs.gov.

Sincerely,

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Erin Black, MDCH
Mindy Morrell, CMCS
Lynell Sanderson, CMCS

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the 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.R02.01**
E. **Proposed Effective Date:** *(mm/dd/yy)*
04/01/15
Approved Effective Date: 04/01/15
Approved Effective Date of Waiver being Amended: 10/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of the amendment is to add a cost adjustor payment to the SEDW for dates of service on or after April 1, 2015. The cost adjustor payment allows the Community Mental Health Service Programs (CMHSPs) to earn additional federal dollars to partially cover the cost of SEDW services that the CMHSP funded with non-Medicaid resources. If approved, this change will take effect April 1, 2015. MDCH is also submitting a HCBS Settings Transition Plan to comply with the federal requirements on home and community-based settings.

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.; 3.b.; Main 6.I and
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-4; B-5
☑ **Appendix C – Participant Services**	C-5.1 & 2
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	G-2-c
☐ **Appendix H**	
☑ **Appendix I – Financial Accountability**	I-2.a.

Component of the Approved Waiver	Subsection(s)
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**
- [x] **Other**

Specify:
The purpose of the amendment is to add a cost adjustor payment to the SEDW for dates of service on or after April 1, 2015. The cost adjustor payment allows the Community Mental Health Service Programs (CMHSPs) to earn additional federal dollars to partially cover the cost of SEDW services that the CMHSP funded with non-Medicaid resources. If approved, this change will take effect April 1, 2015.

MDCH is also submitting a HCBS Settings Transition Plan to comply with the federal requirements on home and community-based settings.

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.R02.01
Draft ID: MI.004.02.01

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

E. Proposed Effective Date of Waiver being Amended: 10/01/13
Approved Effective Date of Waiver being Amended: 10/01/13

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*):

- [x] **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

- [ ] **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- ☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- ○ **Not applicable**
- ◉ **Applicable**

Check the applicable authority or authorities:

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

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

SEDW(b)(4)waiver application submitted to CMS was approved with a begin date of April 1, 2012. The (b)(4) waiver is set to expire September 30, 2013 and the State is requesting the renewal of the (b)(4) effective October 1, 2013.

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 21th 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. Oversight of the SEDW is provided by MDCH, which is the Single State Medicaid Agency. Two administrations within MDCH - Behavioral Health and Developmental Disabilities Administration (BHDDA) and the Medical Services Administration (MSA) have responsibility for operations and payments, respectively. The SEDW is a Medicaid fee-for-service program administered locally by Community Mental Health Service Programs (CMHSPs); and which is contracted by MDCH as providers of services to SEDW enrollees under the auspices of a §1915(b)(4) Fee-for-Service (FFS) Selective Contract concurrent waiver. Services are provided directly by CMHSPs and their contracted providers. When medically necessary, SEDW consumers may receive any of the Mental Health State Plan services and waiver services identified in Appendix C of this §1915(c) renewal waiver application. Consumers enrolled in the SEDW may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

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 (IPOS).

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, 19 or 20 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 21rst birthday.

The SEDW is currently limited to thirty-six counties and twenty-four CMHSPs. Michigan is requesting to add one county, Oceana, within one Community Mental Health Services Program (CMHSP), West Michigan Community Mental Health System, to the geographic region for the SEDW.

• Allegan County CMH Services (Allegan County)
• Bay-Arenac Behavioral Health (Bay and Arenac Counties)
• Berrien Mental Health Authority (Berrien County)
• CMH of Central Michigan (comprised of Clare, Gladwin, Isabella, Mecosta, Midland and Osceola)
• CMH Services of Muskegon County
• Detroit-Wayne County CMH Agency
• CMH Authority of Clinton-Eaton-Ingham Counties (Clinton, Eaton and Ingham Counties)
• Kalamazoo CMH Services
• Genesee Health System (Genesee County)
• Gratiot County CMH Services (Gratiot County)
• Lifeways (Jackson and Hillsdale Counties)
• Livingston County CMH Authority
• Macomb County CMH Services
• Network 180 (for Kent County)
• Newaygo County Mental Health Center
• Northern Lakes CMH Authority (Grand Traverse, Leelanau, Roscommon and Wexford Counties)
• Oakland County CMH Authority
• Pathways (Marquette County only)
• Saginaw County CMH Authority
• St Clair County CMH Authority
• Summit Pointe (Calhoun County),
• Van Buren CMH Authority
• Washtenaw Community Health Organization
• Woodlands Behavioral Health Network (Cass County)

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 thirty-six counties and twenty-four CMHSPs. Michigan is requesting to add one county, Oceana, within one Community Mental Health Services Program (CMHSP), West Michigan Community Mental Health System, to the geographic region for the SEDW.

The counties and CMHSPs currently approved are:

• Allegan County CMH Services (Allegan County)
• Bay-Arenac Behavioral Health (Bay and Arenac Counties)
• Berrien Mental Health Authority (Berrien County)
• CMH of Central Michigan (comprised of Clare, Gladwin, Isabella, Mecosta, Midland and Osceola)
• CMH Services of Muskegon County
• Detroit-Wayne County CMH Agency
• CMH Authority of Clinton-Eaton-Ingham Counties (Clinton, Eaton and Ingham Counties)
• Kalamazoo CMH Services
• Genesee Health System
• Gratiot County CMH Services (Gratiot County)
• Lifeways (Jackson and Hillsdale Counties)
• Livingston County CMH Authority
• Macomb County CMH Services
• Network 180 (for Kent County)
• Newaygo County Mental Health Center
• Northern Lakes CMH Authority (Grand Traverse, Leelanau, Roscommon and Wexford Counties)
• Oakland County CMH Authority
• Pathways (Marquette County only)
• Saginaw County CMH Authority
• St Clair County CMH Authority
• Summit Pointe (Calhoun County),
• Van Buren CMH Authority

- Washtenaw Community Health Organization
- Woodlands Behavioral Health Network (Cass County)

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
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 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. Communication was sent to all the CMHSPs informing them our MDCH's intent to renew the SEDW waiver. In January 2013, MDCH conducted an informational phone conference with all interested Community Mental Health Services Programs regarding becoming a participating site for the Waiver for Children with Serious Emotional Disturbances. As a result of that phone conference, one county, Oceana, within one CMHSP, West Michigan Community Mental Health System, expressed interest in becoming a

participating site for the SEDW.

On April 28, 2013, a notice of intent to submit a request to renew the SEDW was sent to Tribal Chairs and Health Directors. The letter is posted on the MDCH website. Additionally, the MDCH Tribal Liaison spoke about the changes at the Tribal meetings she attends. Public notice was submitted to the newspapers on July 30, 2013. MDCH has received no input regarding the SEDW renewal application as a result of of either the tribal notification or the public notice.

2014 Request for Amendment:
On October 30, 2014, MDCH sent a notice of intent to all Tribal Chairs and Health Directors to submit amendments to the Section 1915(c) and Section 1915(b)(4) Home and Community-Based Services Waiver for Children with Serious Emotional Disturbances (SEDW) and the Home and Community Based (HCB) Settings Transition Plan for the SEDW. No comments were received in response to that Notice of Intent.

On November 24, 2014, MDCH sent the amendments and draft HCB Settings transition plan to stakeholders and posted the documents on the MDCH, BHDDA website for public comment. MDCH also posted a public notice in various newspapers across Michigan and sent out a press release to solicit public comment. MDCH developed a dedicated email address for public comment. No comments were received in response to these notices.

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

Signature: Stephen Fitton

State Medicaid Director or Designee

Submission Date: Mar 19, 2015

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

Last Name: Fitton

First Name: Stephen F.

Title: Director

Agency: Medical Services Administration

Address:

Address 2: P.O. Box 30479

City:

Attachments

400 South Pine Street

State:

Attachment #1: Lansing

Zip: **Michigan**

Phone:

Transition Plan 48909

Check the box next to any of the

Fax:

following changes from the current approved waiver. (517) 241-7882 **Ext:** ☐ **TTY**

Check all

E-mail:

boxes that apply. (517) 335-5007

☐ **Replacing an approved waiver with this waiver.**

FittonS@michigan.gov

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

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

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Section 1: Assessment

Action Item Description Start Date End Date Sources Key Stakeholders

Align all policies, standards, and requirements with HCBS settings requirements

Settings are presumed compliant with HCBS with rules and therefore it is not necessary to align polices, standards and requirements. 12/1/14 1/31/15 DCH Federal Compliance Section, BHDDA

Submit SEDW Waiver Amendment Submit Waiver amendment to Centers for Medicare and Medicaid Services (CMS) following public comment period on transition plan. 12/30/14 12/30/14 CMS Waiver Document DCH Federal Compliance Section, BHDDA, Medical Services Administration (MSA)

Assess settings covered by the waiver State of Michigan conducts preliminary assessment of the types of SEDW residential and

nonresidential services and the characteristics of the settings. Foster Family homes, per licensing rules, meet the HCBS regulatory requirements. Foster family homes have four or fewer foster children. Supervision and care is done by the foster parent and the child is treated as a family member with the same rights as any other child in the home. As part of the licensing process there is an interview with the parent about expectations and commitment to the child as being a family member. In addition, there is monthly monitoring by the foster care worker via interview with the child. Family homes, including family foster homes, independent living settings (not provider owned or operated) have presumed compliance with the rule. No remediation activity will be conducted. 12/1/14 3/1/15 State of Michigan licensing law and rules. DCH Federal Compliance Section, BHDDA

Section 2: Outreach and Engagement
Action Item Description Start Date End Date Sources Key Stakeholders
Initial Transition Plan Developed Immediate Stakeholder input gathered 11/24/14 12/24/14 Advocates, General stakeholder meeting DCH, CMH, Advocates, enrollees
Public Notice- Assessment Plan Review DCH makes public notice calling for comment on the SEDW transition plan: On November 24, 2014, MDCH sent the amendments and draft HCB Settings transition plan to stakeholders and posted the documents on the MDCH, BHDDA website for public comment. MDCH also posted a public notice in various newspapers across Michigan and sent out a press release to solicit public comment. MDCH developed a dedicated email address for public comment. No comments were received in response to these notices. 11/24/14 12/24/14 HCBS Transition Plan DCH, CMH, Advocates, enrollees
Incorporate Public comments- Transition Plan DCH will collect public comment through dedicated email address, in person, or via fax. 11/24/14 12/24/14 Dedicated email box DCH
Public Comment- collection and plan revisions DCH incorporates appropriate changes to Transition Plan based on public comments. 11/24/14 12/24/14 Transition Plan, Public Comments DCH

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)-Behavioral Health/Developmental Disabilities Administration
   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a)The Michigan Department of Community Health (MDCH) is the single State Medicaid Agency and is comprised of three administrations: The Medical Services Administration (MSA), which administers Medicaid for MDCH; the Behavioral Health and Developmental Disabilities Administration (BHDDA) Administration, which operates the Waiver for Children with Serious Emotional Disturbances (SEDW) and other mental health programs; and the Public Health Administration. More specifically, the MDCH-BHDDA performs the following operational and administrative functions: all administrative functions related to the SEDW including review and approval of initial waiver applications and renewal certifications submitted by Community Mental Health Services Programs (CMHSPs), SEDW waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS assurances, including financial accountability. Additionally, MDCH-BHDDA 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 / reevaluation activities, conduct site reviews, conduct training and technical assistance, provide input for updating the Medicaid Provider Manual concerning waiver requirements and implementation.

   b) The Memorandum of Understanding between MSA and BHDDA outlines the responsibilities for administration and oversight of the waiver. As indicated in a) above, the responsibilities of the BHDDA include: monitoring and managing the annual SEDW appropriation; managing waiver enrollment against approved limits; performing prior authorization of selected services for the SEDW; establishing eligibility for the SEDW; conducting and monitoring quality assurance at the CMHSP level; providing training and technical assistance concerning waiver requirements; completing waiver applications, renewals, amendments and 372 reports related to the SEDW (which are then submitted to MSA for review and approval). The responsibilities of the MSA include: establishing fee screens; setting and publishing Medicaid policy, including policy related to the SEDW; determining Medicaid eligibility; reviewing, approving and submitting waiver applications, renewals, amendments and 372 reports to CMS; processing Medicaid claims and make payments based on established methodology. If the Medicaid Director has a concern as to how the BHDDA fulfills their responsibility as outlined in the MOU, he/she would take concerns to the BHDDA Director.

   c) The MDCH Director oversees and provides guidance related to the administration and operation of the SEDW through bi-weekly and as-needed (if issues arise) contacts with the directors of MDCH-BHDDAA and MDCH-MSA. While the administration of the waiver falls within the jurisdiction of the MDCH-BHDDA, all reports, amendments, renewals, and applications for the waivers are reviewed, approved and then submitted to CMS by the State Medicaid Director within MSA.

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

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

   ○ **Not applicable**

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

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

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

   MDCH contracts with local/regional non-state public entities known as Community Mental Health Services Programs (CMHSP) established under the authority of the Michigan Mental Health Code. The concurrent §1915(b)(4) waiver allows for selectively contracting with Community Mental Health Services Programs (CMHSP) as the provider of services to SEDW consumers effective 4/1/2012. CMHSPs are delegated the responsibility to perform the following activities and functions: disseminating information concerning the waiver to potential enrollees; assisting consumers in applying for needed mental health services, including assessment of eligibility for the SEDW; conducting initial level of care evaluations and level-of-care reevaluations; assuring that consumers have been given a of waiver services in lieu of Psychiatric Hosptial care; that consumers have choice among service providers who are under contract with or employed by the CMHSP or; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the consumer's needs; conducting prior authorization and utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining a network of qualified providers sufficient to meet the consumers' needs.

   ☐ **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:
   The MDCH-BHDDA is responsible for assessing the performance of the CMHSPs in conducting waiver operational and administrative functions. MDCH monitors CMHSPs through the site review process, financial reviews, and waiver enrollment oversight. The review protocols used by both are organized in a way that addresses the functions delegated by MDCH to the participating CMHSPs for the SEDW. The delegated functions included in the review protocol are: level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; provider qualifications and enrollment. MDCH manages enrollment against approved limits by reviewing, approving and processing applications and renewal certifications submitted by CMHSPs and by processing terminations submitted by CMHSPs.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   Within MDCH-BHDDA, the Division of Quality Management and Planning division, monitors implementation of the §1915(c) SED waiver by CMHSPs. The Quality Management Planning division has responsibility for performing on-site reviews at each of the approved participating CMHSPs. MDCH sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs to conduct comprehensive biennial site reviews to ensure that Michigan's 1915 (c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all consumers served by Michigan's Section 1915 (c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers'.

   The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical

Incident Reporting System and verification that the process is being implemented per MDCH policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDCH policy; follow up on reported critical incidents regarding medication errors; monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code.

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDCH staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:
• Includes services and supports that align with and address all assessed needs
• addresses health and safety risks
• is developed in accordance with MDCH policy and procedures, including utilizing person centered/family centered planning
• is updated at least annually

Clinical record reviews are also completed to determine that participants are afforded choice between services and institutional care and between/among service providers and that services are provided as identified in the IPOS.

MDCH site review staff conducts consumer interviews with at least one child and family whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews may be conducted in the provider's office, over the telephone or at the child's home.

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. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH. Results of the MDCH on-site reviews are shared with MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Within MDCH-BHDDA, the Bureau of Community Mental Health Services has responsibility for operation of the SEDW on a day-to-day basis. This includes: monitoring and managing the SEDW annual appropriation; managing waiver enrollment against approved limits; establishing clinical eligibility for the waiver; conducting and monitoring quality assurance at the PIHP/CMHSP level; providing training and technical assistance concerning waiver requirements; completing SED waiver renewal applications, amendments and CMS-372 reports for submission to CMS; reviewing and consulting with CMHSPs when the Site Review Team has identified issues related to delegated functions; monitoring health and welfare issues by way of recipient rights complaints, Critical Incidents, Medicaid fair hearing requests.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of CMHSPs that implement quality assurance/improvement activities as required by contract. Numerator: Number of CMHSPs that implement required quality assurance/improvement activities.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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):
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: EQR	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: sampling methodology determined by EQR
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of CMHSPs implementing prior authorizations according to established policy.
Numerator: Number of CMHSPs implementing prior authorizations according to policy.
Denominator: All CMHSPs.

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: proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial, statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of compliance issues for provider qualifications that were remediated within 90 days. Numerator: Number of compliance issues for provider qualifications remediated within 90 days. Denominator: All provider qualifications compliance issues.

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of administrative hearings related to utilization management issues. Numerator: number of administrative hearings related to utilization management. Denominator: All administrative hearings.

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of IPOS compliance issues that were remediated within 90 days. Numerator: Number of IPOS compliance issues remediated within 90 days. Denominator: All IPOS compliance issues.

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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). MDCH sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs to conduct comprehensive biennial site reviews to ensure that Michigan's 1915 (c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all consumers served by Michigan's Section 1915 (c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers'.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical Incident Reporting System and verification that the process is being implemented per MDCH policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDCH policy; follow up on reported critical incidents regarding medication errors; monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code.

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDCH staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:
• Includes services and supports that align with and address all assessed needs
• addresses health and safety risks
• is developed in accordance with MDCH policy and procedures, including utilizing person centered/family centered planning
• is updated at least annually
Clinical record reviews are also completed to determine that participants are afforded choice between services and institutional care and between/among service providers and that services are provided as identified in the IPOS.

MDCH site review staff conducts consumer interviews with at least one child and family whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews may be conducted in the provider's office, over the telephone or at the child's home.

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. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH.

Results of the MDCH on-site reviews are shared with MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

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**

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 Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☑ **Mental Illness**					
	☐	**Mental Illness**			
	☑	**Serious Emotional Disturbance**	0	21	

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 19, or age 20 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 21th 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, (living at home with their parent or legal guardian), 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 21th 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.

The site review process includes review of plans, including transition plans. The site review process is a strategy to identify individual and systems issues including issues related to transition planning. Transition planning for children/youth enrolled in the waiver is part of a plan of service and the wraparound planning process and is individualized to each child/youth. Many children/youth may receive services from adult mental health services or they may receive services from other systems (Vocational, housing, etc.) and this is part of the transition planning that occurs. This will assist the youth/young adults in making a smooth transition to adult mental health or community based services.

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	804
Year 2	969
Year 3	969
Year 4	969
Year 5	969

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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 24 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 24 CMHSPs are comprised of Allegan County CMH Services, Bay-Arenac Behavioral Health, Berrien Mental Health Authority, CMH of Central Michigan, CMH Services of Muskegon County, Detroit-Wayne County CMH Agency, CMH Authority of Clinton-Eaton-Ingham Counties, Kalamazoo CMH Services, Genesee Health System (Genesee County), Gratiot County CMH Services, Lifeways, Livingston County CMH Authority, Macomb County CMH Services, Network 180, Newaygo County Mental Health Center, Northern Lakes CMH Authority , Oakland County CMH Authority, Pathways (Marquette County only), Saginaw County CMH Authority, St Clair County CMH Authority, Summit Pointe(Calhoun County),Van Buren CMH Authority, Washtenaw Community Health Organization, Woodlands Behavioral Health Network.

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.

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. When the original county becomes aware the family will be moving, the CMHSP will assist

the family by coordinating the transfer with the receiving county and will notify MDCH with the expected date of transfer. When the family moves, the receiving county will identify the Child and Family Team. The Team will determine if the current IPOS will be adopted as written, revised, or a new person-centered planning/family-centered practice meeting will be scheduled. The receiving county will submit a new Waiver Certification form along with the start date of services to MDCH.

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.

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

The waiver provides for entrance of all eligible participants through a two-tier process grounded in 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.

When an individual is determined by the Community Team to be eligible for Wraparound Services, a further review is conducted to determine if the child also appears to meet criteria for the SEDW. If so, the Community Team makes a referral to the CMHSP. The CMHSP assesses eligibility, including if the individual meets the level-of-care (LOC) for the SEDW. This determination is based on two things: whether the individual meets the criteria for and is at risk of hospitalization in a state psychiatric hospital, as defined in the Michigan Medicaid Provider Manual; and whether the child demonstrates serious functional limitations that impair his/her ability to perform in the community. As part of this process, the CMHSP determines level of functional limitation using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS), as appropriate for age. For those individuals meeting the LOC for the waiver, the CMHSP discusses choice of waiver services over hospitalization with the family, completes a Waiver Certification and application for each candidate and submits it to MDCH for review, approval, and enrollment in the waiver.

Although CMHSPs typically receive referrals for the SEDW from the Community Team, a family could make an application for the SEDW directly to the CMHSP. In this case, the CMHSP would proceed with determining if the individual meets eligibility criteria for the waiver, including LOC. In this way, an evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

The state will develop a detailed timeline for the state to implement a process for state approval and denial of all eligibility determinations for all applications for the SEDW.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [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)**
- [x] **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:

42 CFR §435.110, 42 CFR §435.116, 42 CFR §435.118

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:

- [x] **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 7)

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. 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:

  The state is using post eligibility rules for the period between January 1, 2014 and December 31, 2018 as per Section 24.04 of the ACA. Michigan is using the same allowance for the waiver participants and amounts for medical and remedial care under spousal impoverishment post eligilbity rules that it uses under the regular post eligibility rules.

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

- **Not Applicable (see instructions)**
- **AFDC need standard**

- **Medically needy income standard**
- **The following dollar amount:**

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

  Specify:
- **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

- **The following standard included under the State plan**

  Select one:

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

    (*select one*):

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

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

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

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

    Specify:
- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:
- **Other**

  Specify:

  The state is using post eligibility rules for the period between January 1, 2014 and December 31, 2018 as per Section 24.04 of the ACA. Michigan is using the same allowance for the waiver participants and amounts for medical and remedial care under spousal impoverishment post eligilbity rules that it uses under the regular post eligibility rules.

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

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

Specify:

The state is using post eligibility rules for the period between January 1, 2014 and December 31, 2018 as per Section 24.04 of the ACA. Michigan is using the same allowance for the waiver participants and amounts for medical and remedial care under spousal impoverishment post eligilbity rules that it uses under the regular post eligibility rules.

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

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

  The state is using post eligibility rules for the period between January 1, 2014 and December 31, 2018 as per Section 24.04 of the ACA. Michigan is using the same allowance for the waiver participants and amounts for medical and remedial care under spousal impoverishment post eligilbity rules that it uses under the regular post eligibility rules.

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 (6 of 7)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- **The following dollar amount:**

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

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

  Specify formula:

- **Other**

  Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-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):

- (selected) **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**
- (selected) **By an entity under contract with the Medicaid agency.**

Specify the entity:

Level of Care evaluations and reevaluations are performed by the participating CMHSPs under contract with the MDCH Behavioral Health Developmental Disabilities Administration.

- **Other**

Specify:

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

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 the March 2013 MDCH Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes chart.

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 Severity of Illness/Intensity of Service 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.

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:

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 re-evaluations 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 (IPOS); 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 the Web Support Application (WSA) and is used to identify children coming up for reevaluation/recertification. The CMHSP can access a report in the WSA that identifies when reevaluation/recertifications are due for the children they serve. CMHSP Wraparound Facilitator must submit a reevaluation/recertification packet within 365 days of the previous years certification, as stated above.

   MDCH also monitors the statewide report to track past due reevaluations/recertifications.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**

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

   i. **Sub-Assurances:**

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

         Performance Measures

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

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

Performance Measure:
Number and percent of newly enrolled waiver consumers who have a need for a State Psychiatric Hospital level of care (LOC) prior to receipt of services. Numerator: Number of newly enrolled waiver consumers who have received a State Psychiatric Hospital level of care (LOC) prior to receipt of services. Denominator: All new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Certification form

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:

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled waiver consumers that are reevaluated within 365 days of their initial level of care (LOC) evaluation or their last annual LOC reevaluation. Numerator: Number of enrolled consumers who LOCs were reevaluated within 365 days of their last LOC evaluation. Denominator: All enrolled consumers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver certification form

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

Performance Measures

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

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

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

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial, statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate Random Sample, 95% confidence interval
	☑ **Other** Specify: binenial, state wide data gathered over a 2 year period	

Data Aggregation and Analysis:

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

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 are 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.
The state will develop a detailed timeline for the state to implement a process for state approval and denial of all eligibility determinations for all applications for the SEDW. This process will be fully implemented by October 1, 2014.

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 a copy is maintained by the CMHSP in the consumer's clinical record and the original 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 contract between MDCH and PIHPs/CMHSPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. Each PIHP/CMHSP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP/CMHSP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHP/CMHSPs access system.

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

The State's contract with CMHSPs requires that CMHSPs comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency. The contract addresses access to services by "limited English proficient persons" throughout the contract. Requirements include: equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance in the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency; that materials are written at the 4th grade reading level to the extent possible; and that materials shall be available in the languages appropriate to the people served within the CMHSP's area.

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	**Home Care Training, Non-Family**		
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):

HCBS Taxonomy:

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

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

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

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

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Foster family home; Foster family group home
Agency	CMHSP or an agency contracted to the CMHSP
Individual	Individual respite provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Foster family home; Foster family group home
Provider Qualifications
License *(specify):*
Foster Care Providers are licensed under MCL 222.122.
Certificate *(specify):*
NA
Other Standard *(specify):*
The agency must be contracted by the CMHSP to provide respite services to SEDW consumers.

Direct care, aide level staff employed by the agency must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed; in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien); able to perform basic first aid procedures; and is trained in the individual's plan of service, as applicable.
Verification of Provider Qualifications
Entity Responsible for Verification:

The Michigan Department of Human Services (MDHS) is the licensing authority and is responsible for issuing and renewing licenses for these providers. MDHS also verifies proivder qualifications during regular and special investigation visits.

The CMHSP is responsible for verifiying provider qualifications prior to contracting with the provider. The Foster Family Home and Foster Family Group homes are responsible for assuring that all employees providing this service meet the provider qualifications as identified in "other standard" above.

Frequency of Verification:

Licenses are issued/renewed for a two-year period. CMHSPs and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

CMHSP or an agency contracted to the CMHSP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDCH as a CMHSP or the agency must be contracted by the CMHSP to provide respite services to SEDW consumers.

The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g)Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Direct care, aide level staff employed by the agency must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed; in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien); able to perform basic first aid procedures; and is trained in the individual's plan of service, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Individual respite provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
Aides must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed; in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien); able to perform basic first aid procedures; and is trained in the individual's plan of service, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:
The CMHSP verifies provider qualifications.

Frequency of Verification:
prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Child Therapeutic Foster Care

HCBS Taxonomy:

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

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

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

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

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	An agency contracted to the 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:
An agency contracted to the 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):*
CTFC providers must be certified by MDCH.
Other Standard *(specify):*
The child foster care home must be contracted by the CMHSP to provide child therapeutic foster care services to SEDW consumers.
Verification of Provider Qualifications
Entity Responsible for Verification:
The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers.
Frequency of Verification:
The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Supports

HCBS Taxonomy:

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

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

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

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

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 IPOS, 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	CMHSP or an agency contracted to the CMHSP
Individual	CLS aide

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Agency

Provider Type:
CMHSP or an agency contracted to the CMHSP

Provider Qualifications

License *(specify):*
NA

Certificate *(specify):*
NA

Other Standard *(specify):*
The agency must be certified by MDCH as a CMHSP or be contracted by the CMHSP to provide CLS services to SEDW consumers.

The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g)Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Direct care, aide level staff employed by the CMHSP must be a responsible adult at least 18 years of age and be; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed, in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony related to the kind of duty he/she would be performing, or not an illegal alien) able to perform basic first aid procedures; and is trained in the individuals plan of service, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:
MDCH verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:
MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Individual

Provider Type:
CLS aide

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed; in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien) able to perform basic first aid procedures; and is trained in the individual's plan of service, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHSP verifies provider qualifications.

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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**
- [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

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):*
NA
Other Standard *(specify):*
NA
Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider.
Frequency of Verification:
MDCH verifies CMHSP certifications on a triennial basis.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope)*:

This training and counseling service is provided by a clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Community Health PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional as specified in other standard section and contracted by the CMHSP.
Agency	CMHSP or agency contracted to the CMHSP (e.g., clinical service agency providers, out-patient clinics)

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Clinical professional as specified in other standard section and contracted by the CMHSP.

Provider Qualifications

License *(specify):*
The direct clinical service provider must maintain any current registration, license, certification or credential required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

Other Standard *(specify):*
Service providers for Family Home Care Training must be clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Community Health PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:
CMHSPs are responsible for verifying contract service providers' qualifications.

Frequency of Verification:
prior to delivery of service and every two years thereafter.

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 or agency contracted to the CMHSP (e.g., clinical service agency providers, out-patient clinics)

Provider Qualifications

License *(specify):*
The direct clinical service provider must maintain any current registration, license, certification or credential required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDCH as a CMHSP or the agency must be contracted by the CMHSP to provide family home care training services to SEDW consumers.

The agency must be certified by MDCH as a CMHSP or the agency must be contracted by the CMHSP to provide family home care training services to SEDW consumers. The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider is their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Service providers for Family Home Care Training must be clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Community Health PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

The service provider is selected on the basis of their competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Support and Training

HCBS Taxonomy:

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

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

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

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

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 IPOS; 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 IPOS, 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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CMHSP or agency contracted to the CMHSP

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 or agency contracted to the CMHSP

Provider Qualifications

License *(specify):*

NA

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 agency must be certified by MDCH as a CMHSP or the agency must be contracted by the CMHSP to provide family support and training services to SEDW consumers.

The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g)Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

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 verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Care Training, Non-Family

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

This

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

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

service provides coaching, supervision and monitoring of Community Living Support (CLS) staff by clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The professional staff work with CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage. Professional staff train, supervise and monitor CLS staff to ensure appropriateness of service delivery and continuity of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Up to four sessions per day but no more than 12 sessions per 90 day period.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional as specified in other standard section and contracted by the CMHSP.
Agency	CMHSPs; agencies contracted to CMHSPs (e.g., clinical service agency providers, out-patient clinics)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Training, Non-Family

Provider Category:
Individual

Provider Type:
Clinical professional as specified in other standard section and contracted by the CMHSP.

Provider Qualifications

License *(specify):*
The direct clinical service provider must maintain any current registration, license, certification or credential required by his or her profession to practice in the State of Michigan.

Certificate *(specify):*
NA

Other Standard *(specify):*
Service providers for Home Care Training, Non-Family must be clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Community Health PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

CMHSPs are responsible for verifying contract service providers' qualifications.

Frequency of Verification:

prior to delivery of service and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Training, Non-Family

Provider Category:

Agency

Provider Type:

CMHSPs; agencies contracted to CMHSPs (e.g., clinical service agency providers, out-patient clinics)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDCH as a CMHSP or the agency must be contracted by the CMHSP to provide home care training, non family services to SEDW consumers.

The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g)Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

The hands-on service provider must be a clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Community Health PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDCH verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Therapeutic Activities

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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 IPOS. The IPOS 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 IPOS. Providers are identified through the wraparound planning process and participate in the development of an IPOS 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	CMHSPs or other agency on contract to the CMHSP

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:
CMHSPs or other agency on contract to the CMHSP
Provider Qualifications
License *(specify):*
NA
Certificate *(specify):*
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 Board, Inc. (ATCB)
Other Standard *(specify):*
The agency must be certified by MDCH as a CMHSP or the agency must be contracted by the CMHSP to provide Therapeutic Activities services to SEDW consumers.

The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g)Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.
Verification of Provider Qualifications
Entity Responsible for Verification:
MDCH verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.
Frequency of Verification:
MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Therapeutic Overnight Camping

HCBS Taxonomy:

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

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

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

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

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 IPOS. 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**
- [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	Camps

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:
Camps
Provider Qualifications
License *(specify):*
Camps are licensed by the Department of Human Services (DHS)
Certificate *(specify):*
NA
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:
CMHSPs
Frequency of Verification:
CMHSPs verify that contracted agencies are licensed. The contract agencies verify that direct care staff meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Wraparound

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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 or an agency contracted to the CMHSP

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 or an agency contracted to the CMHSP

Provider Qualifications

License *(specify):*
NA

Certificate *(specify):*
NA

Other Standard *(specify):*
The agency must be certified by MDCH as a CMHSP or be contracted by the CMHSP to provide Wraparound services to SEDW consumers.

The MDCH/CMHSP Managed Mental Health Supports and Services Contract, 6.4.1, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g)Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h)Financing conditions consistent with this contract; i) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Wraparound facilitators must:
1. Complete MDCH wraparound training;
2. 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;
3. Have a criminal history screen, including state and local child protection agency registries; and
4. 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 verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:
MDCH verifies CMHSP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two 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. Michigan requires documentation of the Internet Criminal History Access Tool (ICHAT) which allows the search of public records contained in the Michigan Criminal History Record maintained by the Michigan State Police, Criminal Justice Information Center as evidence that a provider is in "good standing with the law". 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 (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an 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.*

Michigan does not allow payments 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.

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

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

- **Other policy.**

Specify:

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

Any entity that meets 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, can be certified by MDCH as a Community Mental Health Service Program (CMHSP), and can enroll with Medicaid as a CMHSP. MDCH contracts with CMHSPs to carry out operational functions related to the SEDW, including directly providing at least one service and assuring a wide array of qualified service providers to provide a comprehensive array of services to meet the needs of children on the SEDW.

In order to provide an appropriate, adequate array of service providers, each CMHSP establishes a procurement schedule/process for contracting with direct service providers. In addition, CMHSPs routinely expand their provider panel to meet the needs of SEDW consumers and upon request of consumers to add direct service providers.

The CMHSP is the Provider of services. Individuals are given a choice of direct service providers that contract with the CMHSP. If the family identifies a qualified provider, they refer that provider to the CMHSP to become affiliated with the CMHSP. Qualified providers chosen by the beneficiary should be placed on the provider panel.

The §1915(b)(4) waiver operates concurrently with this §1915(c) waiver, effective 4/1/2012. This Fee-for-Service (FFS) Selective Contracting waiver formalizes MDCH's relationship with CMHSPs as the provider of services for all children enrolled in the SEDW.

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**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of providers of SEDW services that continue to meet credentialing standards. Numerator: Number of providers of SEDW services that continue to meet credentialing standards. Denominator: All providers of SEDW services.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year time period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of applicants for provision of SEDW services that meet initial credentialing standards prior to provider enrollment. Numerator: Number of applicants for provision of SEDW services that meet initial credentialing standards prior to provider enrollment. Denominator: All provider applicants for provision of SEDW services.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide dta gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of non-licensed, non-certified waiver service providers that meet provider qualifications as stated in the Michigan Medicaid Provider Manual. Numerator: Number of non -licensed, non-certified waiver providers that meet qualifications. Denominator: All non-licensed, non-certified waiver 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: proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period.	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of waiver providers that meet staff training requirements. Numerator: Number of waiver service providers that meet staff training requirements. Denominator: All waiver 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: proportionate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year	

Data Aggregation and Analysis:

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

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

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. 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. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH. Results of the MDCH on-site reviews are shared with MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

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 C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. All children and youth enrolled in the SEDW are living in their family home, in a foster family home or living independently and these settings are all in compliance.

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 (IPOS)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [x] **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:

- [x] **Other**

  Specify the individuals and their qualifications:

  The Wraparound Facilitator, who leads the Child and Family Team in the development of the IPOS, 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. 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. The Child and Family Team includes those persons most familiar with the child and family, plus service providers and community members. The Child and Family Team ensures that the plan is family-driven, not agency driven. The inclusion of these parties in the planning process helps to mitigate the service provider's influence on the planning process.

Additionally, the utilization review process, in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity, and effective use of resources, provides safeguards to mitigate the influence service providers on the planning process.

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 Individual 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 Individual 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 IPOS, 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 IPOS every six months. The supervisor will review the IPOS 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 IPOS' 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 IPOS. However, as with all aspects of the IPOS 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.

During the pre-planning meeting, families are informed that they can refer potential qualified providers to the CMHSP to become a part of the CMHSP provider network. Subsequent to the pre-planning meeting, once a child and family's needs are identified and prioritized a IPOS is created. The IPOS 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, led by the Wraparound Facilitor, continue to identify qualified providers from which the family may choose. The child and family choice drives the IPOS. 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 IPOS.

The §1915(b)(4) waiver operates concurrently with this §1915(c) waiver and was initially effective 4/1/2012. The §1915(b)(4) waiver expires on 9/30/13. Consequently, the state is requesting a renewal of the waiver effective October 1, 2013. This Fee-for-Service (FFS) Selective Contracting waiver formalizes MDCH's relationship with CMHSPs as the provider of services for all children enrolled in the SEDW.

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) site review team currently conduct biennial on-site visits to the PIHP/CMHSPs to ensure that plans of service for children on the SEDW meet the federal assurance and sub assurances related to participant centered planning and service delivery. The state chooses a representative sample of service plans to review with a 95% confidence interval. Because the SED waiver is a fee-for-service program, day to day operations are performed by the approved CMHSPs.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

The CMHSP maintains the records.

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 process requires a minimum of two in person meetings per month. 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**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS reflects their goals and preferences.
Numerator: Number of enrolled consumers whose IPOS reflects their goals and preferences.
Denominator: All enrolled consumers.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number of percent of enrolled consumers whose IPOS includes services and supports that align with their assessed needs. Numerator: Number of enrolled consumers whose IPOS includes services and supports that align with their assessed needs. Denominator: All enrolled consumers.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS has adequate strategies to address their assessed health and safety risks. Numerator: Number of enrolled consumers whose IPOS had adequate strategies to address their assessed health and safety risks. Denominator: All enrolled consumers with identified health and safety risks.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of IPOS for enrolled consumers that are developed in accordance with policies and procedures established by MDCH. Numerator: Number of IPOS for enrolled consumers that are developed in accordance with policies and procedures established by MDCH. Denominator: All IPOS for enrolled consumers.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS changed when the individual's needs changed. Numerator: Number of enrolled consumers whose IPOS was changed when the individual's needs changed. Denominator: All enrolled consumers whose needs changed.

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: proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS are updated within 365 days of their last plan of service. Numerator: Number of enrolled consumers whose IPOS were updated wtihin 365 days of their last plan of services. Denominator: All enrolled consumers.

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: Proportinate random sample, 95% random sample
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of IPOS for enrolled consumers in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency. Numerator: Number of IPOS for enrolled consumers with services and supports provided as specified in the plan, including type, amount, scope, duration and frequency. Denominator: All IPOS for enrolled consumers.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: Biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

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

Performance Measure:
Number and percent of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers. Num: Number of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers. Den: All parents/guardians of enrolled consumers.

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: Proportinate random sample, 95% confidence level
	☑ **Other** Specify: biennal statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of parents or legal guardians of enrolled consumers who are informed of their right to choose among the various waiver services. Numerator: Number of parents or legal guardians of enrolled consumers who are informed of their right to choose among the various waiver services. Denominator: All parents/guardians of enrolled consumers.

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: proportinate random sample, 95% confidence levle
	☑ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of parents or legal guardians of waiver consumers who are offered the choice between SEDW services and services in the State Psychiatric Hospital. Numerator: All parents or legal guardians of waiver consumer who are offered the choie between SEDW services and services in the State Psychiatric Hospital. Demoninator: All parents or legal guardians of waiver consumers.

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

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Initial LOC 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.
The Child and Family Team is charged with developing a IPOS 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 IPOS incorporates strengths and is culturally relevant. The Child and Family Team review the IPOS 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 IPOS 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 IPOS: the individual IPOS addresses the consumer's assessed needs and identifies the services by type, amount, frequency and

duration; the IPOS was developed in accordance with the Wraparound principals; and services were delivered in accordance with the IPOS.

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 Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. 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. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH.

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

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

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

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

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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 a 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**

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

   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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

No. This Appendix does not apply *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

Michigan's critical incident management system is a statewide system encompassing everyone who receives public mental health services. The local Community Mental Health Services Program (CMHSP) is responsible for some functions of the critical incident management system, while the Prepaid Inpatient Health Plans (PIHPs) are responsible for others. Where the function is performed by the PIHP, the link between the CMHSP and the PIHP will be described.

MDCH-BHDDA requires the CMHSPs to report critical incident data and related information as measures of how well the CMHSP and its contracted providers monitor the care of vulnerable service recipients, including SEDW consumers. The MDCH-BHDDA requires reporting on the following critical events: abuse, exploitation or neglect that results in emergency medical treatment or hospitalization, suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest of consumer. Allegations of abuse, exploitation and neglect are also reported to the local CMHSP Office of Recipient Rights (ORR). Definitions follow after the description of the system for reporting.

Three reporting processes, each with a purpose and intended outcome, comprise the backbone of Michigan's system for assuring participant safeguards. The reporting processes are: Event Notification (EN), Sentinel Event (SE) Root Cause Analysis and Findings, and the Critical Incident Reporting System (CIRS). When an event occurs, the first step is that staff generates an Incident Report. Depending on the event, it may be subject to the requirements of one or more of the reporting processes. As an example, if a child on the SEDW were to die, section 6.1.1 (EN) of the MDCH/CMHSP contract requires the CMHSP to report to the State immediately any death that "occurs as a result of suspected staff member action or inaction, or any death that is the subject of recipient rights, licensing, or police investigation." This report must be "submitted electronically within 48 hours of the death, or the CMHSP's receipt of notification that a rights, licensing, and/or police investigation has commenced." The purpose and outcome of immediate reporting is to assure health and welfare of any other recipients and coordination of investigations resulting from the incident. If the death is considered "unexpected", the contract requires that the CMHSP commence a SE root-cause analysis within 48 hours. "Unexpected deaths" are defined as "those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect." The purpose of this process is to identify the root cause(s) and identify strategies for quality improvement and prevention of future incidents. This process is completed at the local CMHSP level and is available for review by the EQR and the State during site reviews. The third process requires reporting of all deaths, including those of recipients of SEDW services, via the CIRS - regardless of whether that death also required immediate reporting under the EN requirement and/or SE root-cause analysis and findings. The purpose of this requirement is to complete state-level analysis with outcomes to improve quality throughout the system, as well as to address individual-specific issues identified by the CIRS. In addition to the above, CMHSP

program staff would alert MDCH through the Waiver Support Application, indicating the child's case is closed and the reason for the closure.

EVENT NOTIFICATION (EN): Section 6.1.1 of the contract between MDCH and CMHSP requires that the CMHSP "immediately notify MDCH" of any of the following egregious events: any death that occurs as a result of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation; relocation of a consumer's placement due to licensing issues; an occurrence that requires the relocation of a CMHSP or provider panel service site, governance, or administrative operation for more than 24 hours; and conviction of a CMHSP or provider panel staff member for any offense related to performance of their job duties or responsibilities. Deaths must be reported electronically within 48 hours of either the death or the CMHSP's receipt of notification that a rights, licensing, and/or policy investigation has begun. Notification of the other events must be made telephonically or via other forms of communication to MDCH's contract management staff within five business days.

The CMHSP is responsible to assure the immediate health and welfare of all SEDW consumers, as well as that of any other mental health recipients who could be at risk as a result of the reported incident. All other qualified Medicaid enrolled providers providing services to SEDW consumers are responsible to assure the health and welfare of the children they serve. If an event is reported for a child on the SEDW, waiver program staff follow-up with the CMHSP within 1 business day of the report to assure the health and welfare of the child. The CMHSP is required to submit a plan of correction that identifies systems changes in place that will prevent reoccurrence of such an event. Depending on the event, MDCH staff may make a site visit to the CMHSP to follow up on the implementation of the plan of correction.

CRITICAL INCIDENT REPORTING SYSTEM (CIRS): The CIRS enables MDCH to receive data on individual consumers within specified timeframes, depending on the type of event. Children enrolled in the SEDW are a reportable population in the CIRS. All providers of waiver services must report incidents, such as an injury or the use of physical management permitted for intervention in an emergency, on an incident report form that is submitted to the CMHSP. For any of the required events, the CMHSP must submit data to the PIHP to report to MDCH-BHDDA: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. Program staff follow-up on incidents reported in the CIRS, and a plan of correction may be required by the CMHSP depending on the incident. On-site follow up may also occur during biennial site reviews. The data from the CIRS is used for federal reporting purposes, to identify potential trends and to determine the type of technical assistance, consultation, or training that needs to be provided to the CMHSPs. The CMHSP is responsible to assure the immediate health and welfare of the SEDW participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident. Providers on contract with the CMHSPs must report Critical Incidents in a manner that allows the PIHP to report incidents to the MDCH within the timeframes listed below. Timeframes for reporting the five specified events in the CIRS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the cause of death was determined. For the purpose of the CIRS, a consumer's death shall be reported as a suicide when either one of the following two conditions exists, the CMHSP serving the consumer determines, through its death review process, that the consumer's death was a suicide, or the official death report (i.e., coroner's report) indicates that the consumer's death was a suicide. If 90 calendar days has elapsed without a determination of cause of death, the CMHSP must submit a "best judgment" determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

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

Emergency Medical Treatment Due To Injury Or Medication Error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization Due to Injury Or Medication Error: Due within 60 days after the end of the month in which the hospitalization began.

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

SENTINEL EVENT (SE): Any provider of waiver services report incidents, such as an injury or the use of physical management permitted for intervention in an emergency, on an incident report form that is submitted to the CMHSP. The CMHSP must review the incident to determine if it meets the criteria and definitions for SE and is related to practice of care as described in G-1-d. If the incident if a SE, the CMHSP must undertake a process that begins with a root cause analysis and ends with quality improvement activities. Depending on the type of incident, it may also be required to be reported on the CIRS through the PIHP to MDCH. The local CMHSP ORR would also receive a copy of the incident report and may also investigate as described in the CMHSP ORR section in G-1-d. If the CMHSP ORR substantiates a rights violation related to abuse, including exploitation, or neglect, the ORR makes recommendations for remediation to the CMHSP director. Appropriate remedial action must be taken and documented when there is a substantiated recipient rights violation per the MDCH/CMHSP Contract, Attachment C6.8.1.1. The CMHSP is responsible to assure the immediate health and welfare of the SEDW participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident.

OFFICE OF RECIPIENT RIGHTS: Allegations of abuse (including exploitation) and neglect are reported to the local CMHSP ORR through the incident report forms and/or recipient rights complaint forms. Any person employed by the MDCH, each CMHSP, each licensed hospital, and each service provider under contract with the MDCH has a duty to report any suspected abuse and/or neglect to

the local ORR. Michigan law and rules require the mandatory reporting of recipient rights complaints in a timely manner to the CMHSP ORR. CMHSP policies further specify that reports of rights violations are immediately reported to their ORR. Reporting may be done in writing or by phone or by other means of communication, such as fax. If the ORR substantiates a rights violation related to abuse, including exploitation or neglect, the ORR makes a recommendation for remediation to the CMHSP director. Appropriate remedial action must be taken and documented when there is a substantiated recipient rights violation per the MDCH/CMHSP contract.

Certain situations involving suspected abuse and neglect must also be reported to law enforcement or CPS. The Michigan Mental Health Code requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: [the reporter] "immediately shall make or cause to be made, by telephone or otherwise, an oral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police. Within 72 hours after making the oral report, the reporting individual shall file a written report with the law enforcement agency to which the oral report was made and with the chief administrator of the facility or agency responsible for the recipient (330.1723)."

Michigan's Child Protection Law requires the following with regard to reporting suspected child abuse or neglect to DHS CPS for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: [the reporter] "immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this Act (722.623)."

OTHERS: Other agencies, such as law enforcement, protective services, or licensing, may receive reports of allegations of abuse, neglect, and exploitation. Where SEDW consumers receive waiver services in licensed settings (e.g., respite care in licensed camps and foster family settings), Michigan law and rules require the licensee to complete an Incident/Accident Report (a copy of which is forwarded to the CMHSP ORR) and to make a reasonable attempt to contact the child's parent/legal guardian and responsible agency by telephone and follow the attempt with a written report to the designated representative, responsible agency and the children's foster care licensing division within 48 hours. The incident/accident report from the licensee is provided to the CMHSP, the responsible agency, which would assure the immediate health and welfare of the consumer, as well as that of any other mental health recipients in the home. A licensee is required to report any of the following:

R 400.9413 Unusual incident notification.
Rule 413. (1) A foster parent shall immediately notify the agency of the death of a foster child.
(2) A foster parent shall immediately notify the agency of the removal or attempted removal of a foster child from a foster home by any person not authorized by the agency.
(3) A foster parent shall notify the agency within 24 hours of determining that a foster child is missing.
(4) A foster parent shall notify the agency within 24 hours after the foster parent knows of any of the following:
(a) Any illness that results in inpatient hospitalization of a foster child.
(b) Any accident or injury of a foster child that requires medical treatment by a licensed or registered health care person.
(c) A foster child's involvement with law enforcement authorities.
Members of the general public may also make reports of incidents of alleged abuse, neglect, exploitation or other concerns. Contact information for local community mental health services programs is available on each CMHSP's website and phone numbers are listed in the phone book. Contact information for the local offices of recipient rights is located on the state ORR's web page and has been modified to make the information easier to access related to how and where to report concerns of suspected abuse, neglect or exploitation. The SEDW web page contains a link to the State's ORR web page.

DEFINITIONS:

Definitions of Abuse and Neglect (MDCH Administrative Rule 330.7001):
Abuse is divided into three categories, Abuse Class I, Abuse Class II and Abuse Class III. Neglect is also divided into three categories, Neglect Class I and Neglect Class II and Neglect Class III. Abuse Class I and II and Neglect Class I and II are required to be reported to MDCH on a semi-annual basis as each involves some level of physical or emotional harm to the recipient or involves sexual abuse.

Abuse Class I means a non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient.

Serious Physical Harm means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Sexual Abuse means any of the following:
(i) Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
(ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.

Sexual Contact means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering

the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:
(i) Revenge.
(ii) To inflict humiliation.
(iii) Out of anger.

Sexual Penetration means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Abuse Class II means any of the following:
(i) A non accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to nonserious physical harm to a recipient.
(ii) The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm.
(iii) Any action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a recipient.
(iv) An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.
(v) Exploitation of a recipient by an employee, volunteer, or agent of a provider.

Emotional Harm means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Exploitation means an action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Nonserious Physical Harm means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.

Neglect Class I means either of the following:
(i) Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient.
(ii) The failure to report apparent or suspected abuse Class I or neglect Class I of a recipient.

Neglect Class II means either of the following:
(i) Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service and that cause or contribute to non serious physical harm or emotional harm to a recipient.
(ii) The failure to report apparent or suspected abuse Class II or neglect Class II of a recipient.

Definitions for Sentinel Events (SE):
Sentinel Event: 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 risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (JCAHO, 1998) [excerpt from MDCH-BHDDA Guidance on entine Reporting (PIHPs)].

Incident: any of the following which should be reviewed to determine whether it meets the criteria for SE:
- death of recipient - that which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
- serious illness requiring admission to hospital – does not include planned surgeries, whether inpatient or outpatient, or admissions directly related to the natural course of the person's chronic illness or underlying condition.
- alleged case of abuse or neglect
- injury from accident or abuse to the recipient requiring emergency room visit or admission to hospital
- serious challenging behavior - those not already addressed in a treatment plan and include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence. Serious physical harm is defined by the Administrative Rules for Mental Health (300.7001) as “physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.”
- arrest and/or conviction - any arrest or conviction that occurs with an individual who is in the reportable population at the time the arrest or conviction takes place.
- medication error a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage that resulted in death or serious injury or the risk thereof. It does not include instances in which consumers refused medication.

Definitions for Critical Incident Reporting System (CIRS):
Suicide - a Consumer’s death shall be reported as a suicide when either one of the following two conditions exists:
a. The CMHSP serving the consumer determines, through its death review process, that the consumer’s death was a suicide, or
b. The official death report (i.e., coroner’s report) indicates that the consumer’s death was a suicide.

Non-suicide Death - any death, for consumers in the reportable population, that was not otherwise reported as a suicide.

Emergency Medical Treatment Due To Injury Or Medication Error - Situations where an injury to a consumer or a medication error results in face-to-face emergency treatment being provided by medical staff. Any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms should be reported, provided the treatment was sought due to an injury or medication error.

Medication Error - a situation where a mistake is made when a consumer takes prescribed medication (i.e., incorrect dosage taken, prescription medication taken that is not prescribed, medication taken at wrong time, medication used improperly), or a situation where a non-prescription medication is taken improperly.

Injury - bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body. Examples of injuries include bruises (except those due to illness), contusions, muscle sprains, and broken bones.

Hospitalization Due To Injury Or Medication Error - Admission to a general medical facility due to Injury or Medication Error. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

Arrest - Situations where a consumer is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a consumer is transported for the purpose of receiving emergency mental health services, or situations where a consumer is held in protective custody, are not considered to be an arrest.

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

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDCH entitled “YOUR RIGHTS When Receiving Mental Health Services in Michigan” at the time of admission into services and periodically thereafter. The SEDW consumer's Wraparound Facilitator or other QMHP provides information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of SEDW services and subsequently as often as needed by the consumer or the parent/guardian, but at least annually during a person-centered planning meeting. This is in accordance with Section 330.1706 of the Mental Health Code: “… applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available or review by applicants and recipients." From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the Mental Health Code mandated protections from abuse, neglect, and exploitation, and how consumers (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the consumer may have experienced abuse, neglect or exploitation. In an effort to make it easier for members of the general public, including family members, to report suspected abuse, neglect, or exploitation, the state ORR has modified its web page on how and where to report.

Chapter 7 of the Michigan Mental Health Code also requires that every CMHSP ORR must assure that all program sites, whether directly operated or through contract with the CMHSP, have rights booklets available in public areas for recipients, guardians, care-givers, etc. The booklet describes the various rights afforded the individual under the U.S. Constitution, Michigan Constitution, the Michigan Mental Health Code and MDCH Administrative Rules as
well as contact information for the CMHSP ORR if the recipient, legal representative, or anyone on behalf of the recipient feels that the recipient’s rights have been violated, including the right to be free from abuse or neglect.

Section 6.3.1 of the MDCH-BHDDA/CMHSP contract requires that each CMHSP must provide customer services and there is an assigned customer services coordinator for each CMHSP that oversees customer services at the CMHSP. In addition, each CMHSP is either a stand-alone PIHP or is in an affiliation of PIHPs where Attachment P.6.3.1.1 of the MDCH-BHDDA/PIHP contract also applies. A customer services handbook which has been approved by MDCH is provided to individuals at the time services are initiated and offered again at least annually. Individuals
are provided information regarding mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a consumer. The Customer Services Unit may also, upon request of the consumer or family, assist with contacting the local Office of Recipient Rights for assistance with an issue related to abuse, neglect or exploitation.

The ORR also houses a Training Unit to ensure that recipient rights initiatives are consistently implemented statewide. In addition to training staff of CMHSPs and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients’ rights. CMHSP ORRs conduct rights informational sessions for consumers, family members, advocates and interested others. Additionally, the MDCH holds annual Recipient Rights, Consumer, Wraparound and Home and Community Based Waiver Conferences, all of which include consumers and/or their families. These conferences provided Recipient Rights training that describe consumer rights and the compliant resolution and appeal process.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical incidents may be received and investigated by the CMHSP ORR and/or the CMHSP, as well as by law enforcement or other state agencies as applicable depending on the nature of the incident.

EVENT NOTIFICATION: Per section 6.1.1 of the MDCH-BHDDA/CMHSP contract, the CMHSP must immediately report certain events to MDCH, as described in Section G-1-b, and as required by Attachment P 6.7.1.1 of the MDCH/PIHP contract. For deaths, the PIHP must submit to MDCH within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurs as a result of suspected staff member action or inaction. The written report will include consumer information, date, time and place of death (if in a foster care setting, the foster care license #), final determination of cause of death (from coroner's report or autopsy), summary of conditions (physical, emotional) and treatment or interventions preceding death, any quality improvement actions taken as a result of an unexpected or preventable death, and the PIHP/CMHSP's plan for monitoring to assure any quality improvement actions are implemented. Immediate event reporting is considered an egregious situation and is reviewed through the MDCH internal process.

SENTINEL EVENT: The CMHSP must review the incident to determine if it meets the criteria and definitions for sentinel events and is related to practice of care. Depending on the type of incident, it may also be required to report on the Critical Incident Reporting System through the PIHP to MDCH. In the MDCH-BHDDA/CMHSP contract, Attachment C 6.8.1.1 requires that each CMHSP must have a Quality Improvement Program (QIP). The QIP describes, and the CMHSP implements, the process of the review and follow-up of sentinel events. The CMHSP has two business days after a critical incident occurred to determine if it is a sentinel event and commence the root-cause analysis. The outcome of this review is a classification of incidents as either sentinel events or non-sentinel events. Sentinel events include: death of the recipient, any accident or physical illness that requires hospitalization, incidents that involve arrest or conviction of the recipient, emergency physical management interventions used for controlling serious challenging behaviors and medication errors (definitions in G-1-b). Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, including all SEDW consumers (deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), who at the time of their deaths were receiving waiver services, must be reviewed and must include:
- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

The use of physical management, permitted for intervention in emergencies only, is considered a critical incident that must be managed and reported through the PIHP according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined in the MDCH/CMHSP contract attachment C6.8.3.1 as "a technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan." Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The MDCH requires CMHSPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the CMHSP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. [excerpt from MDCH Guidance on Sentinel Event Reporting].

CRITICAL INCIDENT REPORTING SYSTEM: The CIRS requires the CMHSP to report the following events through the PIHP to MDCH-BHDDA: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. Incidents reported in the CIRS would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse, including exploitation or neglect. Additionally, some of the incidents reported in the CIRS, such as a death or injury, could result in a criminal investigation or referral to Child Protective Services (CPS). All events are included in aggregate trend and analysis reports. Events that are considered priorities, such as certain types of deaths (suicide and accidental deaths for example) and injuries (related to the use of restrictive interventions or medication errors for example), are reviewed through the MDCH internal process. During biennial on-site reviews, MDCH-BHDDA verifies the process for Critical Incident Reporting is being implemented per MDCH policy. If it is not, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP (including CMHSP affiliates as applicable. Section G-1-b of this application defines incidents and identifies time lines for reporting to the state.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner.Subject to delays involving pending action by external agencies as described in subsection (5), the ORR shall complete the investigation not later than

90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the consumer within five days acknowledging receipt of the complaint and then provides written updates every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report of the investigation including the conclusion by the ORR and the action or plan of action to remedy a violation to the complainant, recipient if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights.

Information gathered from investigations is reviewed for trends, and becomes a focus of the state ORR visits to CMHSPs. Aggregate data are shared with MDCH Behavioral Health and Developmental Disabilities Management team, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

OTHER: In the event of a reported incident of a child, DHS-CPS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring consumer safety. The CMHSP ORR is responsible for investigating rights violations. The DHS Bureau of Child and Adult Licensing (BCAL) is responsible for investigating licensing rule violations. Law enforcement may also be conducting an investigation related to possible criminal activity in conjunction with the above. Local DHS offices must have signed agreements with their respective CMH boards to cover roles and responsibilities for handling APS investigations in mental health settings. The protocol for joint operating agreements and the model agreements for this coordination for reporting, investigating and sharing information are in the Adult Services Manual (DHS-ASM 256).

If, during an MDCH on-site visit, the site review team member identified an issue that places a particpant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

EVENT NOTIFICATION: Events requiring "immediate notification", as identified in G-1-b, are considered egregious events and are reviewed through the MDCH internal process. If it is determined that the event is for an SEDW participant, immediate follow up by MDCH staff will occur.

CRITICAL INCIDENT REPORTING SYSTEM: The CIRS enable MDCH to better monitor the types of events which occur in particular populations, such as the ability to monitor incidents for SEDW consumers. Since individual consumer identification is included with each event, MDCH can look for potential trends by comparing reportable events to data already existing in the Quality Improvement/Encounter files. MDCH will oversee the CMHSP responsibility for critical incident management for the SED waiver population by measuring the rate of critical incidents for SEDW consumers. After establishing a baseline "occurrence" rate, MDCH will set targets for reductions in the rate of critical incidents that will result from systems improvement strategies identified in Appendix H and oversight of critical incidents. MDCH staff reviews the incidents reported and identifies priority events that warrant additional review through the MDCH internal process. As a result of the review, MDCH may contact the CMHSP when concerns arise regarding SEDW consumers. Technical assistance, consultation, and referrals for additional follow-up or training are provided as required. On-site follow-up may be provided by site review or waiver staff on reported incidents. More frequent reviews by MDCH staff may be required in addition to site reviews, depending on the situation. During site reviews, MDCH staff examine the critical incident reporting process, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of reportable event would re-occur. Any noted shortcomings in the processes or outcomes would be reflected in the CMHSP's written site review report which would in turn require submission of a corrective action plan within 30 days. The corrective action plan is reviewed by MDCH. If the submitted plan is satisfactory, it is formally approved. Any less than satisfactory plan would be returned for revision and the process for review and approval by MDCH would be repeated until a satisfactory plan is achieved. This state oversight by the QMP assures the necessary processes are in place for participant safeguards.

As part of Michigan's overall quality oversight of public mental health services, including the SEDW, the External Quality Reviews examine the performance indicator for sentinel event reporting to assure that the QAPIP at each PIHP (and affiliate CMHSPs as applicable) describes the process for review and follow-up of sentinel events. Because of the nature of sentinel event reporting, a score is given to validate that the processes are in place for review and follow-up. This report indicates that the processes are in place for all recipients of mental health services, including SEDW consumers. MDCH monitors the EQR report and its recommendations and may follow-up with PIHPs/CMHSPs that are outliers in a particular area of the report.

OFFICE OF RECIPIENT RIGHTS: On a semi-annual basis, local CMHSP ORRs report to MDCH the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations, 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. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDCH include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local ORR, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semiannual and annual complaint data reports to the MDCH Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon

specific population, including SEDW consumers. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

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

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

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

The Michigan Mental Health Code defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700 [j]). The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]).

MDCH requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742).

The State does not prohibit the use of a medication or drug when it is used to manage, control or extinguish an individual's behavior or restrict the individual's freedom of movement that is not a standard treatment or dosage for the individual's condition. When used in this manner, the State classifies the use of a medication or drug as an "Intrusive Technique". CMS considers the use of medications or drugs in the manner to constitute chemical restraint.

Use of Intrusive Techniques is addressed in the MDCH Technical Requirement for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Concurrent §1915(b)/(c) Waiver Program contract between MDCH-BHDDA and the PIHPs; and the Agreement Between MDCH-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1. The CMHSPs must use a specially constituted committee, often referred to as a "behavior treatment plan review committee" or "Committee", to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. Typically each CMHSP has a Committee; however, a PIHP comprised of an affiliation of CMHSPs may have one region-wide Committee. The MDCH Technical Requirement for Behavior Treatment Plan Review Committees states that plans that are forwarded to the Committee for review shall be accompanied by "the plan for monitoring and staff training to assure consistent implementation and documentation of the interventions(s)." The Wraparound Facilitator is responsible to verify that staff are trained on the plan, including training on any intrusive technique identified in the plan. Additionally, the professional staff who developed the IPOS is responsible to ensure that staff are trained to carry out the plan. During site reviews, for the selected sample of records, MDCH verifies that staff are trained on the plan, including training on any intrusive techniques identified in the IPOS.

Further, MDCH Administrative Rules 330.7199 requires (in part):

-The plan [of services and supports] shall identify, at a minimum, all of the following:

Any restrictions or limitations of the recipient's rights. Such restrictions, limitations or intrusive behavior treatment techniques shall be reviewed and approved by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. Any restriction or limitation shall be justified, time-limited and clearly documented in the plan of service. Documentation shall be included that describes attempts that

have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code is done by the Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with consumers, their families and/or staff. If the site review team discovers the use of seclusion or restraint as defined above, the CMHSP will be required to provide a plan of correction within 48 hours. Each CMHSP ORR established by the Mental Health Code would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the ORR during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protections of rights but in no case less than annually. The Michigan Mental Health Code establishes rights offices at the MDCH, CMHSPs and licensed psychiatric facilities. All are internal, and are subordinate only to the Department, CMHSP or licensed hospital director. If there is a rights complaint against the CMHSP Director, the investigation must be conducted by another CMHSP rights office or the MDCH Office of Recipient Rights. Further safeguards include the statutorily created and required Recipient Rights Advisory Committees whose primary purpose is to protect the rights office from "pressures that could interfere with the impartial, evenhanded and thorough performance of its functions." (MCL 330.1756, MCL 330.1757) and a two-step rights appeal process. The first level is at the CMHSP. The local Appeals committee is comprised of at least 3 members of the Recipient Rights Advisory Committee, 2 CMHSP Board members and 2 primary consumers. None may be employed by MDCH or the CMHSP. Included in the potential decisions by the Committee, a case may be sent to the MDCH Office of Recipient Rights for external investigation. The second level of appeal is to the Michigan Department of Community Health Appeals Division where an Appeal Review Officer reviews the conclusion of the local Appeals Committee and either upholds or sends the case back to the CMHSP rights office for re-investigation.

The Department of Human Services (DHS) BCAL is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of DHS-BCAL during announced or unannounced inspections and at the time of the biennial licensure process. If the CMHSP rights office receives a complaint involving a consumer residing in a licensed foster care home, the rights office will notify DHS BCAL, Adult Protective Services or Children's Protective Services as applicable and as required by law. BCAL and APS/CPS will notify the CMHSP rights offices as well when each receives a complaint involving a consumer of CMHSP services. In most cases the investigation will be coordinated between the 3 entities. In addition, if BCAL were to identify an egregious situation, such as unlawful use of restraint or seclusion, the director of BCAL (or designee) may contact the director of the Division of Quality Management and Planning (or designee) for immediate action. Examples of immediate action, which are in addition to ORR investigation, may include follow-up by the contract division or a site visit by a central office staff person. Regular meetings are also held between BHDDA and BCAL to discuss issues of concern for mental health consumers served in licensed settings.

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

MDCH monitors the critical incident reporting through the CIRS. Any death or injury requiring emergency treatment or hospitalization resulting from the use of restrictive interventions would be reported within the timeframes specified in G-1 -b.

MDCH-BHDDA oversees the activities of the CMHSP (or PIHP as applicable) Behavior Treatment Plan Review Committees through quarterly reporting from Committees to MDCH for SEDW consumers whose plans include the use of intrusive or restrictive techniques and biennial Site Reviews. If issues or critical incidents related to the use of restrictive interventions is noted, MDCH-BHDDA may require the PIHP and CMHSP staff to receive training in the culture of gentleness and positive behavioral supports, as well as recommend other approaches or strategies as appropriate. In FY 2013, MDCH-BHDDA is piloting a streamlined process to improve the process for submitting quarterly summary data from the Behavior Treatment Plan Review Committees (BTRC). By the end of FY2013, this improved process will be used by all CMHSPs/PIHPs to report data from the BTRCs.

For children on the SEDW, the BTRC data will be submitted by the CMHSPs to the PIHPs which then submit the data to MDCH. At this time, the data submitted includes: frequency of BTRC review; issue being reviewed; incident of harm to self or others or elopement since the last BTRC review; specific interventions approaches; underlying causes ruled out prior to a use of restrictive or intrusive intervention; analysis of recommendations by committee; plan approved or denied. MDCH reviews the data to identify trends, patterns and outliers related to effectiveness or approved plans.

The Site Review Team verifies that the process for the Behavior Treatment Plan Review Committees is being implemented per MDCH policy. If the process is not being implemented per MDCH policy, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP (including CMHSP affiliates as applicable).

The data on the use of intrusive and restrictive techniques must be evaluated by the CMHSP's Quality Improvement Program, and be available for MDCH review as required in the CMHSP contract, Attachment C 6.8.3.1. (section III-H).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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

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

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

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

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

The Michigan Mental Health Code 330.1726 requires (in part):
- A recipient is entitled to unimpeded, private and uncensored communication with others by mail and telephone and to visit with persons of his or her choice;
- The right of a recipient to communicate by mail or telephone or receive visitors shall not be further limited except as authorized in the person's individual plan of services.

The Michigan Mental Health Code 330.1744 requires (in part):
- The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.

MDCH Administrative Rules 330.7199 requires (in part):
-The plan [of services and supports] shall identify, at a minimum, all of the following:
Any restrictions or limitations of the recipient's rights. Such restrictions, limitations or intrusive behavior treatment techniques shall be reviewed and approved by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. Any restriction or limitation shall be justified, time-limited and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

Use of restrictive interventions is addressed in the MDCH Technical Requirement for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Concurrent §1915(b)/(c) Waiver Program contract between MDCH-MHSA and the PIHPs; and the Agreement Between MDCH-MHSA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1. The CMHSPs must use a specially constituted committee, often referred to as a "behavior treatment plan review committee" or "Committee". Typically each CMHSP has a Committee; however, a PIHP comprised of an affiliation of CMHSPs may have one region-wide Committee. The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards contained in the Attachment P 1.4.1. The Committee shall be comprised of at least three individuals, one of whom shall be a licensed psychologist as defined in the Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training and experience in applied behavior analysis; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision making.

The functions of the Committee shall be to:
1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.

Restrictive and intrusive interventions reviewed by the Committee include:

Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Use of aversive techniques is prohibited.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious or non-serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of a recipient in a prone (face down) position, usually on the floor, where force is applied to the recipient's body in a manner that prevents him or her from moving out of the prone position.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excludes dietary restrictions for weight control or medical purposes); or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.

Peer-reviewed literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance"and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

Positive Behavior Support: A set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce problem behaviors such as self-injury, aggression, property destruction, pica, defiance, and disruption.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire behavior treatment plan should be reviewed by the Committee.

5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of service recipients.

Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan has been obtained from the individual, the legal guardian, the parent with legal custody of a minor, or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2])

The behavior treatment plan must address the monitoring and staff training to assure consistent implementation and documentation of the interventions.

The PIHP/CMHSP Behavior Treatment Plan Review Committee must, on a quarterly basis, track and analyze the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
1. Dates and numbers of interventions used.
2. The settings (e.g., group home, day program) where behaviors and interventions occurred
3. Behaviors that initiated the techniques.
4. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
5. Attempts to use positive behavioral supports.
6. Behaviors that resulted in termination of the interventions.
7. Length of time of each intervention.
8. Staff development and training and supervisory guidance to reduce the use of these interventions.

Per Section P1.4.1 of the MDCH/PIHP Contract, physical management is defined as a technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of a recipient in a prone (face down) position, usually on the floor, where force is applied to the recipient's body in a manner that prevents him or her from moving out of the prone position. Physical management is to be used only to address an imminent risk of harm to the individual or others and should be used only for the period of time necessary to ensure health and welfare. Following the use of physical management to address that emergency situation, the sentinel event process begins with root cause analysis and plan of action to prevent use of physical management in the future, which might include revision of the IPOS or review by the Behavior Treatment Review Committee. The use of physical management would also generate an incident report that is reviewed by the CMHSP ORR. If after investigation by the CMHSP ORR, it is determined that staff used physical management (1) when there is not an imminent risk of harm to the recipient or others, (2) if the physical management used is not in compliance with the techniques approved by the CMHSP, (3) the physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service, and/or (4) physical management is used when other lesser restrictive measures were possible but not attempted immediately before the use of physical management, the CMHSP ORR will substantiate Abuse Class II Use of Unreasonable Force, against the staff. The Michigan Mental Health Code mandates that disciplinary action must be taken for any substantiated abuse or neglect.

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

MDCH monitors the critical incident reporting through the CIRS. Any death or injury requiring emergency treatment or hospitalization that resulted from the use of restrictive interventions wouild be reported within the timeframes specified in G-1-b.

MDCH-BHDDA oversees the activities of the CMHSP (or PIHP as applicable) Behavior Treatment Plan Review Committees through quarterly reporting from Committees to MDCH for SEDW consumers whose plans include the use of intrusive or restrictive techniques and biennial Site Reviews. If issues or critical incidents related to the use of restrictive interventions is noted, MDCH-BHDDA may require the PIHP and CMHSP staff to receive training in the culture of gentleness and positive behavioral supports, as well as recommend other approaches or strategies as appropriate. In FY 2013, MDCH-BHDDA is piloting a streamlined process to gather and review quarterly summary data from the Behavior Treatment Plan Review Committees (BTRC). In order to improve the process for submission of BTRC data to MDCH, two PIHPs, comprised of 10 CMHSPs, are piloting the streamlined process. Beginning in FY 14, all CMHSPs/PIHPs will be using the streamlined process to gather and review quarterly summary data from the BTPRC.

For children on the SEDW, the BTRC data will be submitted by the CMHSPs to the PIHPs who then submit the data to MDCH. At this time, the data submitted includes: frequency of BTRC review; issue being reviewed; incident of harm to self or others or elopement since the last BTRC review; specific interventions approaches; Underlying Causes ruled out prior to a use of restrictive or intrusive intervention; plan approved or denied. MDCH reviews the data to identify trends and patterns related to effectiveness or approved plans. Additionally, review of the data allows MDCH to identify geographic regions where the use of restrictive/instrusive interventions is occurring at a higher rate than the average.

The Site Review Team verifies that the process for the Behavior Treatment Plan Review Committees is being

implemented per MDCH policy. If the process is not being implemented per MDCH policy, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP (including CMHSP affiliates as applicable).

The data on the use of intrusive and restrictive techniques must be evaluated by the CMHSP's Quality Improvement Program, and be available for MDCH review as required in the CMHSP contract, Attachment C 6.8.3.1. (section III-H).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

The CMS-approved application was submitted before Appendix G-2-c was added to WMS in March 2014. The State's response for seclusion is combined with information on restraints in Appendix G-2-a, and this Request for Amendment makes no change to Appendix G-2-a. Please refer to G-2-a-i for detail on safeguards concerning the use of seclusion.

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

The CMS-approved application was submitted before Appendix G-2-c was added to WMS in March 2014. The State's response for seclusion is combined with information on restraints in Appendix G-2-a, and this Request for Amendment makes no change to Appendix G-2-a. Please refer to G-2-a-ii for detail about State oversight responsibility regarding the use of seclusion.

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

Most SEDW consumers live with family and medication management and administration are the family's responsibility. In those instances where the consumer and family use licensed settings, the CMHSPs have ongoing responsibility for "second line" management and monitoring of consumer medication regimens. "First line" management and monitoring is the responsibility of the prescribing medical professional. The consumer's IPOS must contain complete information about their medications regimen [i.e., what each medication is for; frequency and dosage; signs and symptoms suggesting/requiring attention, etc]. These details and any other monitoring recommendations from the prescribing professional are shared with the members of the Child and Family Team [as authorized by the consumer and his/her parent], and all provider staff with medication administration/self-administration assistance/ monitoring responsibilities. This helps all within the consumer's planning/service/support network to know when to request a formal medication review outside those scheduled within the plan.

The CMHSP medications monitoring procedure, called a medication review, is by definition the evaluation and monitoring of medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications. The frequency of regular medication reviews must be specified in the consumer's IPOS. The average frequency of medication reviews performed for those consumers who required them is approximately once per quarter.

In addition to the regular medication reviews by the CMHSP medical professionals specified in the plan, home based clinicians and others are trained to spot signs and symptoms of potentially harmful practices. Any of these staff can request an unscheduled medication review and a planning meeting to address any confirmed issues. Also, during Wraparound meetings with the Child and Family Team, if a concern about the child's medications is raised at a Wraparound meeting, the Wraparound Facilitator would ensure that a medication review is scheduled.

Michigan's DHS licenses foster family home and foster family group home settings in which respite services are provided for SEDW consumers, Child Therapeutic Foster Care (CTFC) providers and Therapeutic Overnight Camps. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. DHS licensing inspections occur every two years, as well as conducting special investigations when needed. In addition to staff training required by licensing, all providers must be trained in the child's plan of service, including medications that would be administered while the child was under the care of the licensed provider.

Any use of behavior modifying medications is an intrusive technique as defined in the Agreement between MDCH-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1 and requires specific approval of a Behavior Treatment Plan Review Committee. These requirements are outlined in contracts with the CMHSPs and specify committee membership and review requirements are included in G-2-b. Committee reviews of the use of behavior modifying medications must be completed at least quarterly, but may be completed more frequently at the discretion of the committee. Reports from the Committee must be submitted to MDCH for SEDW consumers on a quarterly basis.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the CMHSP must follow-up to address the consumer's health and welfare as applicable, report through the Critical Incident Reporting System and conduct a sentinel event investigation.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The CIRS captures individually identifiable medication errors for children on the SEDW that required emergency medical treatment or hospitalization. When a hospitalization or emergency medical treatment due to medication error is reported for a child on the SEDW, MDCH staff follow-up with the CMHSP including requiring a plan of correction from the CMHSP to ensure the cause of the medication error is identified and remediated.

The MDCH site review team includes a resgistered nurse with experience in the identification of potentially harmful practices. During biennial site reviews, if a potentially harmful practice is identified at any level, the CMHSP works with the provider to correct the practice.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

The 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.

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

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

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

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

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

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

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

  Medication error is defined as a situation where a mistake is made when a consumer takes prescribed medication (i.e., incorrect dosage taken, prescription medication taken that is not properly prescribed, medication taken at the wrong time, medication used improperly) or a situation where non-prescription medication is taken improperly.

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

MDCH will monitor the critical incidents related to medication errors through the CIRS to monitor for trends and outliers. MDCH may require the CMHSP to receive additional technical assistance or training as a result of CIRS data.

In addition, on-site follow-up may be provided by the site review or waiver staff regarding medication errors. During biennial site reviews, MDCH-BHDDA verifies the process for Critical Incident Reporting is being implemented per MDCH policy. If it is not, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP (including CMHSP affiliates as applicable).

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents reported for SEDW enrollees. Numerator: Number of critical incidents reported for SEDW enrollees. Demonimnator: All SEDW enrollees.

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**

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

Performance Measure:
Number and percent of enrollees requiring hospitalization due to injury related to use of a restrictive intervention. N: Number of enrollees requiring hospitalization due to injury related to the use of a restrictive intervention. D: All enrollees with reported incidents of hospitalization for injuries or medication errors

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrollees requiring hospitalization due to medication error. Numerator: Number of enrollees requiring hospitalization due to medication error. Denominator: All enrollees with reported incidents of hospitalization for injuries or medication error.

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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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.
MDCH will analyze a 100% sample of all reported critical incidents involving SEDW consumers from the CIRS, as well as analyze subcategories of critical incidents reported through the CIRS including who required hospitalization due to an injury related to use of restrictive intervention or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDCH and the Quality Improvement Council are particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effectiveness of preventive strategies.

MDCH also has regular meetings with MDHS Licensing staff to identify issues of concern related to people receiving services in licensed settings. Agendas and meeting notes are maintained.

As indicated elsewhere in this application, each consumer has an IPOS developed based on the child's assessed needs and strengths. The IPOS also identifies a methodology to be used by staff for addressing identified needs. Safety and crisis plans are also developed for each consumer. Required staff training includes training in the IPOS, as well as in Recipient Rights. The IPOS is overseen by the Child and Family 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.
If an incident is reported to the CMHSP ORR or CMHSP, the system described in this Appendix would require the following steps be taken. Any critical incident for a consumer has a short-term response to assure the immediate health and welfare of the consumer for whom the incident was reported and a longer term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services, the agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the consumer's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and 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. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

If an egregious event is reported through the Event Notification or through other sources, MDCH may follow-up through a number of different approaches, including sending a site review nurse or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the CMHSP, requiring additional training for its providers, or other strategies as appropriate. During a on-site visit, if the site review team member identifies an issue that places a consumer in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP/CMHSP, which must be completed in five to seven business days.

Another strategy MDCH may use to address immediate issues for a consumer who has either experienced a critical incident or is a high risk of experiencing a critical incident is through its contract with the Center for Positive Living Supports. The Center offers several services that can address behavioral crisis situations in an effort to prevent a critical incident from occurring or re-occurring. Services include 1) Telephone calls from CMHSP's to the Center are triaged for response and a determination made about what Center services may be required. The Center will assist in identifying the environmental and relationship variables that may be influencing the crisis situation, and will attempt to provide clinical impressions and recommendations. If additional advice or consultations need to occur, the Center clinician will seek that assistance and call the CMHSP back within two hours. Should this consultation not resolve the crisis, the Center will request permission from MDCH for further support from the Center. The Center will conduct an on-site face to face assessment or evaluation of an indivduals's need in order to determine what Center services might be required. The evaluation will result in written recommendations based on observation, record review and interviews with relevant support staff. This service is required before further Center services (i.e. Mobile Training/Crisis Team services or Training/Crisis Transition Home) will be provided. Request for on-site assessment or evaluation must come from a CMHSP Director or designee. 2) a Mobile Training/Crisis Team may be dispatched upon approval by MDCH and after all prerequisites have been met by the CMHSP, including training for its staff in culture of gentleness approaches. Within the first eight hours of service, the individual's care-givers will be asked to participate in the structure and interaction patterns established by the team. The team members will coach and mentor the individual's care-givers in this process. The manager and shift leader, when applicable, need to be the first staff working directly with the Mobile Team and the individual. The team may remain on-site for up to two weeks, unless extended by authorization from MDCH; and 3) a Training and Crisis Transition Home - A CMHSP may request MDCH approval for the use of the Training and Crisis Transition Home once they have exhausted all local options of support and training and have utilized the services of

the Center's Mobile Training/Crisis Team. Utilization of the Training and Crisis Transition Home will occur only after approval by MDCH and the Center.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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 QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 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.

The Quality Improvement Council (QIC), which is comprised of stakeholders representing CMSHPs, PIHPs, advocates, consumers and family members, and MDCH staff, has primary responsibility for identifying and prioritizing needs related to the Quality Improvement Strategy (QIS), which would include changes to SEDW quality processes as applicable. The Quality Improvement Council meets on a bi-monthly basis to review data and information from numerous sources, such as site review findings, 372 reports, state-level workgroups for practice improvement, EQR standard and special project reports, legislative reports, and QAPIP and PIP activities. The QIC determines where there are needs for system improvement and makes recommendations to MDCH to incorporate into system improvement activities. The timeframe for incorporating changes is dependent on whether it is an issue requiring immediate enactment which would be addressed through policy changes or an amendment to the MDCH/CMHSP and MDCH/PIHP contracts. Otherwise, changes to the QIS are generally implemented in conjunction with the annual contracts between MDCH and the PIHPs and CMHPS.

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,Children's Waiver Control #4119.90, and the SEDW Control # 0438.01. The PIHPs/CMHSPs adhere to the same standards of care for each individual served and 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). MDCH sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs to conduct comprehensive biennial site reviews to ensure that Michigan's 1915 (c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all consumers served by Michigan’s Section 1915 (c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers’.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical Incident Reporting System and verification that the process is being implemented per MDCH policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDCH policy; follow up on reported critical incidents regarding medication errors and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan’s Mental Health Code.

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDCH staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:
• Includes services and supports that align with and address all assessed needs
• addresses health and safety risks
• is developed in accordance with MDCH policy and procedures, including utilizing person centered/family centered planning
• is updated at least annually

Clinical record reviews are also completed to determine that participants are afforded choice between services and institutional care and between/among service providers and that services are provided as identified in the IPOS.

MDCH site review staff conducts consumer interviews with at least one child and family whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews may be conducted in the provider's office, over the telephone or at the child's home.

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. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH. Results of the MDCH on-site reviews are shared with MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Results of the MDCH on-site reviews are shared with MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. 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 includes: 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, MDCH staff conduct reviews of all applications and re-certifications for the SEDW.

Data from site reviews and consultations has been used for systems improvement activities. Examples include: providing technical assistance to participating sites during monthly conference calls; mandating technical assistance for sites with high levels of out-of-compliance; completing additional follow up record reviews to ensure that fidelity to the Wraparound model is assured; developing workshops for the Annual Statewide Waiver and Wraparound conferences; 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.

Recipient Rights, Critical Incidents and Site Review findings are reported by waiver population.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: The QI Committee meets bi-monthly. For the PIHPs/CMHSPs and MDCH, QI activities are on-going.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The need for system design changes are identified through the site review process, review of Critical Incident System data, Behavior Treatment Plan Review Committee data, Quality Improvement Council, External Quality Review, and data trend analysis activities discussed in H.1.a. The State receives feedback from a number of sources after implementing a system design change and presents that information to the QIC. The QIC is the primary group with responsibility for reviewing system design changes and assisting the State to determine effectiveness by looking at how PIHPs and CMHSPs are implementing changes, such as how they use new information required.

Additionally, in preparation for the SEDW renewal, the state has been in the process of identifying a valid methodology to allow for a more accurate assessment of need for the SEDW in the identified geographic region. The methodology used to identify the unduplicated count for the five year renewal is based upon the trend in growth in SEDW over the past several years. By applying this methodology, the state determined that the unduplicated count should be reduced beginning in FY 2014.

Beginning in FY 2014, the state plans to increase efforts to ensure that children eligible for the SEDW are identified and served. Initially, efforts will focus on gathering information from stakeholders regarding obstacles to identifying and serving eligible children. A specific plan to address those obstacles will be established and implemented after an analysis of the information is completed.

External Quality Review 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. The EQR consists of desk audits of PIHP documents, two-day on-site visits to PIHPs or both.

One EQR component evaluates PIHP compliance with BBA requirements. The EQR reviews the PIHP/CMHSPs'

implementation of their local Quality Assessment and Performance Improvement Programs (QAPIP) to ensure the plans include the 13 QAPIP standards. The EQR report displays performance on requirements by PIHP and can be used for trend analysis throughout the state.

EQR also validates the PIHPs methodologies for conducting the State mandated project and performance indicators measurement systems.

Performance Improvement Projects: 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 PIHPs to conduct a minimum of two performance improvement projects. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH; in the case of PIHPs with affiliates, the project is affiliation-wide. All PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHPs choose their second performance improvement project.

Performance Indicators: Performance indicators are used to monitor the performance of the PIHP/CMHSP on a number of domains that have been identified as important quality strategies for the mental health system. The CMHSPs are required to report data for performance indicators. MDCH analyzes data against established standards, creates statewide averages and does 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.

As the need to change systems design is identified, those changes are subsequently implemented by MDCH through revisions to PIHP and CMHSP performance requirements and practices. This is accomplished by changing or adding relevant requirements to the PIHP and CMHSP contract, Medicaid Provider Manual, and reporting requirements. Where targets or standards for systems improvement are applicable, they would be incorporated. The MDCH site review protocols are then modified in response to the underlying changes in those requirements and subsequent MDCH site review activities assess PIHP and CMHSP compliance with those system design changes.

Site Review findings are reported to PIHPs/CMHSPs as described in this Appendix and throughout the CMS-approved SEDW Renewal Application. In addition, a number of reports and aggregated data are available on the MDCH web site. While these are not specific to the SEDW, they include: service utilization for children with SED; External Quality Review Summaries; summaries of Adverse Events: Medicaid Performance Indicators: summary cost and expenditure dta; and other repots as required by Michigan's Legislature.

Specific to the SEDW, the state is evaluating data gathered from the Child and Adolescent Functioning Tools (CAFAS) and Family Status Report. The CAFAS is a tool that measures functioning across life domain areas. This is administered at enrollment, every 3 months, and at graduation from the waiver. We also gather data specific to community placement and service array in the Family Status Report.

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

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIS is reviewed on an on-going basis by MDCH-BHDDA staff and the QIC. The QIC also has a formal opportunity to identify issues at a meeting in anticipation of the annual contract renewal. To the extent that the MDCH-MHSA/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract. If the QIC were to identify an issue that would require changes to the contract prior to the expiration of the current contract, the BHDDA could amend the contract. Procedural changes that do not require contract changes can be implemented immediately. Additionally, if issues are identified through trending and analysis, the QIC may make recommendations to BHDDA upper management team to revise the QIS. The final decision on changes to the QIS is made by the BHDDA upper management team.

The MDCH-BHDDA leadership meets regularly with the PIHP and CMHSP directors and quality improvement strategies may be discussed during the course of those meetings. Feedback from the group is used to help evaluate the QI process and identify opportunities for improvements to MDCH-BHDDA management team and the QIC.

As described in a.i. above, trend patterns of effectiveness are evident and have been used to develop strategies for improvement. Data from site reviews and consultations have been used for systems improvement activities. Examples include: developing workshops for the Annual Statewide Waiver conference, Annual Wraparound Conference and developing and identifying topics for technical assistance workshops at both state and local levels to address effective systems of care for this population.

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 requirements 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) Claims for services provided to SEDW enrollees, whether provided by a CMHSP or by a qualified provider contracted by the CMHSP are billed directly by the CMHSP to Medicaid through CHAMPS-the state's CMS approved claims processing system-in accordance with policies and procedures published in the "billing and reimbursement for professionals" section of the Michigan Medicaid Provider Manual. That portion of the manual also contains information about how claims are processed and how providers are notified of MDCH actions. The CMHSP may also choose to use a billing agent. CHAMPS applies a series of edits and determines the amount approved for payment. This is the lesser of the charge for the service or the Medicaid fee screen. 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 IPOS'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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of SEDW claims that are processed in accordance with MDCH policies and procedures. Numerator: Number of SEDW claims processed in accordance with MDCH policies and procedures. Denominator: All SEDW claims submitted to CHAMPS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic claims submitted 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 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: proportinate random sample; 95% confidence level
	☑ **Other** Specify: biennial, statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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 Medicaid automated claims processing system (CHAMPS) edits claims to assure that consumers were enrolled in the CWP Benefit Plan and eligible for Medicaid on the date-of-service. All submitted claims that do not conform to Medicaid billing and reimbursement policies are rejected.

In addition to the automated claims processing system (CHAMPS) edits, the site review team reviews service claims for all SEDW consumers selected for on-site reviews to ensure that the services billed were identified in the IPOS as appropriate to identified needs. If a problem is identified in the course of the site review, the CMHSP is required to address the problem in its plan of correction. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH.

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).

Establishing Costs/Charges for Services:

CMHSPs are bound by their Medicaid Provider Agreements and Master Contracts with MDCH to assure their service charges are determined consistent with Generally Accepted Accounting Principles (GAAP) and OMB Circular A-87 (here after referred to as A-87). Beginning in FY10, for FY09 expenditure reporting, new administrative cost reporting requirements were implemented for all 46 CMHSPs. These reporting requirements distinguish the CMHSP's costs associated with administrative functions from their direct service costs. Compliance with the requirements of A-87 and with the new cost reporting requirements is audited by MDCH using a variety of strategies, as described in I-1, above.

Administrative Costs:

The structure of each CMHSP varies in relationship to its responsibilities. Each CMHSP may perform any number of the following functions: 1) direct service provider, 2) administer one or more waiver programs, or 3) operate as a Pre-paid Inpatient Health Plan (PIHP). The logic of the PIHP/CMHSP Administrative Cost Report enables CMHSPs to separately identify administrative costs associated with these various responsibilities. For purposes of this waiver, the cost report distinguishes administrative costs to adminster the Waiver for Children with Serious Emotional Disturbances (SEDW), from those costs associated with directly delivering services to consumers.

OMB Circular A-87 (A-87) under the section composition of costs makes it clear there is no universal rule for classifying certain costs as either direct or indirect under every accounting system. Therefore, to the extent that these costs are indirect, the requirements are accommodated under the requirement that the CMHSPs report their costs in compliance with the requirements of OMB Circular A-87 (A-87). When these costs are indirect costs as defined in A-87, the CMHSP is obligated to ensure the equitable distribution of these costs based on relative benefits to each funding stream/program. This could require gathering the costs into a cost pool and distributing the costs to other administrative categories. The costs reported on the administrative cost report are the product of each CMHSP's A-87 compliant cost allocations. Therefore, although the administrative cost report does not show these cost allocation steps, they would be documented at the CMHSP in support of the reported administrative costs.

The state has a process in place to monitor this process. Compliance with A-87 will be monitored as part of the annual compliance exam submitted to MDCH by each CMHSP.

MDCH will reimburse CMHSPs the Federal share of actual CMHSP administrative expenditures attributed to the SEDW, as reported on a financial report certified as accurate by the CMHSP and submitted to MDCH, the MDCH/CMHSP cost settlement process and the CMHSP audited financial reports. The amount reimbursed will be determined in compliance with A-87 principles.

Medicaid Payment for Services:

A Medicaid interim payment for each billable SED Waiver and mental health State plan service-in the form of a Medicaid interim fee screen-is established by the State Medicaid Agency. Medicaid interim fee screens are published on the Medicaid web site and available to providers, waiver participants and the general public. Interim fee screens are based on a legislatively-authorized formula applied to the Relative Value Unit (RVU) for the billed HCPCS code. For those services for which there is no RVU, the rate is initially set based on documentation of historical charges for the service, across participating providers. Fee screens are revised as directed by legislative action in the form of revision of the formula applied to the RVU or in the form of across-the-board increases or decreases in providers' fee-screens. Effective January 2015 the state will be using the most current RVU value, updating on a yearly basis. The current Legislatively-authorized conversion factor is 21.53.
Service claims are submitted to MDCH through CHAMPS (as detailed in I-2-b. below) and paid uniformly at the established Medicaid fee screen or billed charge, whichever is less.

Once a year, a final fee screen is determined, as described below. If a provider has charges in excess of the interim fee screen payments, an adjustor payment is made at the end of the year to bring the interim payments up to the final fee screen, or the billed charge, whichever is less.

Final Fee Screen Methodology:

The final fee screen is the year-end maximum amount payable for each service, determined via the following methodology.

1) For the prior Fiscal Year, the fee-for-service paid claims data is extracted from the MDCH Data Warehouse for all SEDW enrollees. For each claim, the extracted data includes: a)the billing CMHSP, b)the unduplicated number of SEDW enrollees that received the service, c)the total number of service units billed, d) the total amount of service charges submitted to Medicaid, and, e)the total Medicaid amount approved for payment.

2) Services provided on a holiday are paid at a premium rate and are removed and extracted to a separate data base. The final fee screen for these services will be set at 150% of the final fee screen for the base service.

3) Transition services which require prior authorization at the local level are also removed from base data, as the authorized amount sets the maximum amount payable and no adjustor payment is made.

4) The average charge per unit is calculated for each CMHSP for each service. The calculated average charge per unit is then arrayed in descending order by service.

5) Each service is reviewed to determine if there is a corresponding HCPCS code within the Medicare Physicians Fee Schedule for Michigan. Where one exists, that fee is set as the final SEDW fee screen. Where there is no corresponding code within the Medicare Physicians Fee Schedule for Michigan, the 90th percentile of the arrayed average unit charge is calculated and set as the final SEDW fee screen.

6) The final fee screens for services that can be provided to more than one (1) beneficiary at a time (e.g., T1005 - respite), are set at 75% of the corresponding final fee screen.

7) The final fee screens for services provided on holidays are set at 150% of the corresponding unmodified procedure's final fee screen.

8) For those procedures billed by only one CMHSP and to which none of the above rules apply, the interim screen is used and no adjustor payment is made.

Source of Non-Federal Share:

The non-Federal share of the interim payments is either paid with local General Fund or other local funds for one group of SEDW consumers or with an MDCH State appropriation for another group of SEDW consumers. As indicated in I-4 b. (Non-Federal Matching Funds, Local Government or Other Sources of the Non-Federal Share of Computable Waiver Costs, Appropriation of Local Government Revenues and Other Local Government Level Sources of Funds): 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. 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. As indicated in I-4 a. (Non-Federal Matching Funds, State Level Sources of the Non-Federal Share of Computable Waiver Costs) the non-Federal share of the interim payments for the group of SEDW consumers in the DHS-Project population is paid with State General Fund dollars appropriated to, and redirected by, the Michigan Department of Human Services (MDHS). For both groups of SEDW consumers, interim payments are made as described below in I-2 b. Flow of Billings. As noted in I-1 Financial Integrity, validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract.

For both groups of children in the SEDW, the non-federal share of the "final fee screen" adjustor payment is general fund from the MDCH State appropriation, allocated to the CMHSPs. This payment is issued to each CMHSP as a gross pay adjustment by the Medicaid, Mental Health & MAIN Support Division within MDCH.

Responsible Entity:

Within MDCH, Michigan's Single State Medicaid Agency, the Medical Services Administration (MSA) establishes the interim fee screens (i.e., service payment rates); the Behavioral Health and Developmental Disabilities Administration (BHDDA) in collaboration with MSA implements the methodology that results in the final fee screens. Oversight of the final fee screen (rate) determination methodology is provided by the staff of MSA and BHDDA. Both the interim and final fee screens are reviewed by the Budget, Accounting and Audit Offices within MDCH.

Informing Waiver Consumers About Service Rates:

As noted above, the rates are published on the MDCH web site. They can be found at http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-272724--,00.html. The fee screens are also available to consumers, as well as the general public, in written form when requested.

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:

Claims for services provided to SEDW enrollees, whether provided by a CMHSP or by a qualified provider contracted by the CMHSP are billed directly by the CMHSP to Medicaid through CHAMPS-the state's CMS approved claims processing system-in accordance with policies and procedures published in the "billing and reimbursement for professionals" section of the Michigan Medicaid Provider Manual. That portion of the manual also contains information about how claims are processed and how providers are notified of MDCH actions. The CMHSP may also choose to use a billing agent. CHAMPS applies a series of edits and determines the amount approved for payment. This is the lesser of the charge for the service or the Medicaid fee screen.

The charge/cost billed to Medicaid by CMHSPs for contracted services does not include the CMHSP's administrative costs. The contract between a CMHSP and a contracted provider specifies the service/s to be provided by the contractor and the amount to be paid the contractor for each service. Contractors bill the CMHSP and are paid by the CMHSP in accordance with the contract. The SEDW is a fee-for-service program, and CMHSPs do not receive a capitated payment for SEDW consumers. CMHSPs bill Medicaid (through CHAMPS) the charge/cost for each service. Medicaid pays the CMHSPs the lesser of the CMHSP's charge/cost and the

established fee-screen for each service.

When a CMHSP contracts for the SEDW services with a contract provider they must only bill the cost of that contract (the amount billed by the contract provider)in the CMHSP Fee for Service billing to MDCH. Otherwise, they would be violating MDCH requirements around fee for service billings. The CMHSP's do not keep part of what they bill MDCH (Medicaid) for the SEDW fee for service billing but must pay it all to the contract providers.

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) Claims processed through CHAMPS in b. above are edited prior to payment for many parameters, including that the consumer was enrolled in the SEDW and Medicaid eligible on the date of service, that the provider was eligible to be paid for services, that the service was one that could be billed on the date of service (procedure validity), and all other edits built into the system (e.g., claim duplication, frequency and quantity limitations).

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

At the time of the QMP Site Review, staff review billings to Medicaid, budgets, IPOSs, case notes, assessments and reports for consumers selected via a proportionate random sample. The review ensures that the services billed were identified in the IPOS as appropriate to identified needs, were recommended by the child's team, and that the services were provided. When the site-review reveals a problem with a billing, the CMHSP must submit a claim adjustment (when necessary) so that Medicaid recoups the inappropriate payment. The CMHSP must also address billing issues in its plan of correction.

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, claims for services provided to SEDW enrollees, whether provided by a CMHSP or by a qualified provider contracted by the CMHSP, are billed directly by the CMHSP to Medicaid through CHAMPS - the State's CMS -approved claims processing system - in accordance with policies and procedures published in the "billing and reimbursement for professionals" section of the Michigan Medicaid Provider Manual. That portion of the manual also contains information about how claims are processed and how providers are notified of MDCH actions. The CMHSP may also choose to use a billing agent. CHAMPS applies all appropriate edits to each claim line. (Edits include verifying the consumer was enrolled in the SEDW on the date-of-service, that the claim is for a billable service, that the quantity billed does not exceed the parameter for the service, and whether the consumer is enrolled in the DHS Pilot.) CHAMPS issues a Remittance Advice (RA) indicating status of the claim (e.g., pend, reject, paid) with applicable "reason/explanation" codes. The "amount approved for payment" is the lesser of charge or fee screen.

At this time, a "suppress warrant" flag is turned on for SEDW claims, as CHAMPS cannot pay claims in the manner consistent with the two sources for match funding. For one group of SEDW consumers, the CMHSP is reimbursed at FMAP only, as the CMHSPs provide the match to the federal share for these consumers either through the State General Fund or local funds. For the second group of SEDW consumers, children in the DHS foster care system, the CMHSP is reimbursed at the gross amount approved for payment. For both groups of consumers, the amount approved for payment by CHAMPS is the lesser of the charge or the Medicaid fee screen. MDCH staff in the Mental Health and CSHCS Support Section within the Bureau of Finance pull a detailed report from CHAMPS and issue payment (FMAP only or total approved for payment) based on whether the consumer is identified as being in the DHS foster care system.

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. These elements identify everything needed to properly identify expenditures on the CMS-64. At the end of each quarter, 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.

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*):

- [x] **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:

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:

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*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **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:

a) State General Fund dollars appropriated to, and redirected by, the Michigan Department of Human Services (MDHS). b) 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. (MDCH sends DHS a quarterly billing of the applicable gross expenditures for SED services; and MDHS reimburses MDCH the GF share at the current year FMAP rate.) The redirected State funds are used as State match for waiver services provided to children in the foster care system, identified by MDHS, and determined eligible for the SED Waiver.

- [ ] **Other State Level Source(s) of Funds.**

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ○ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ◉ **Applicable**

Check each that applies:

- ☑ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

(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	$17.24
13-18	$20.59

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: $17.24 a day
b.) Age 13 - 18: $20.59 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:*

- (selected) **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.**
- (not selected) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

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

Appendix I: Financial Accountability

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

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

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

i. **Co-Pay Arrangement.**

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. **Co-Payment Requirements.**

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

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

Appendix I: Financial Accountability

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

a. **Co-Payment Requirements.**

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

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

Appendix I: Financial Accountability

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

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

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

Appendix I: Financial Accountability

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

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

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

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: 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	8572.65	10152.31	18724.96	33599.86	1484.67	35084.53	16359.57
2	8572.45	10289.37	18861.82	34053.46	1504.71	35558.17	16696.35
3	8572.45	10428.27	19000.72	34513.18	1525.03	36038.21	17037.49
4	8572.45	10569.06	19141.51	34979.11	1545.62	36524.73	17383.22
5	8572.45	10711.74	19284.19	35451.33	1566.48	37017.81	17733.62

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Hospital
Year 1	804	804
Year 2	969	969
Year 3	969	969
Year 4	969	969
Year 5	969	969

Appendix J: Cost Neutrality Demonstration

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

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) for waiver years 1 through 5 (FY 2014 thru FY 2018) of this Renewal Application is based on the ALOS as reported on the CMS-approved annual 372 for FY11; that ALOS was 208.1 days.

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 and the estimated number of units per user were determined in 3 ways: 1) Utilization data from the CMS-approved 372 report for FY11 was used as the basis for calculation of the various elements of Factor D for all services except Community Transition, Family Support and Training and Home Care Training, Non-Family. FY11 utilization data was expressed as a percent and applied to the number of enrollees for which we are requesting approval. The estimated number of units per user was extrapolated from paid-claim data for FY11. 2) For services that were not used during Waiver Year 3 (i.e., Family Support and Training and Community Transition) the estimated number of users from the approved amendment for Waiver Years 2 and 3, respectively, were expressed as a percent and applied to the number of enrollees for which we are requesting approval for Renewal Waiver Years 1 through 5. The number of units per consumer are as estimated for Waiver Years 2 and 3 for each service. 3) Estimated utilization of Home Care Training, Non-Family (for which FY11 data isn't available because the service was added halfway through FY12) is based on estimated utilization of this service for Waiver Year 4 of the approved amendment.
Please Note: When using actual 372 data for projections, it was not possible to exactly match the 372 data for both expenditures and the unduplicated number of consumers using a service when also estimating the average usage of each service because estimates are based on Medicaid fee-screens and claims are paid at the lesser of charge or fee-screen. Our approach is to prepare the demonstration of Factor D based on the actual number of consumers using each service as reported on the 372 and the actual Factor D value (average per capital expenditures for waiver services) as reported on the 372.

(b) The average cost per unit of service is based on the Medicaid Fee Screens, and claims are paid at the lesser of charge or fee screen. No increase in Medicaid fee screens for waiver services is anticipated, therefore no projected growth rate was built into the average unit cost for any service.

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:

Data from the CMS-approved annual 372 report for FY11 was used as the basis for calculation of D' for waiver years 1 through 5 of the renewal application. Medicaid expenditures for other services provided to SEDW enrollees are projected to grow at a rate of 1.35%. The State is using a trend of State historical cost increases as predictive of future costs. Historical cost increases for SEDW waiver and mental health State Plan services from FY 08 – FY 11 were smoothed linearly to produce an annualized trend rate during that period. This annualized historical trend rate is, in our opinion, the best estimate of future costs for this population and includes the impact of practice patterns and utilization per member/per month. Hospital payments for DSH, TEFRA and GME are not included in the D' estimates.

There is no further adjustment in D' as there are no dually eligible (Medicare / Medicaid) consumers served by the SEDW, although they are eligible. There were no Medicare Part D expenditures for SEDW recipients in FY11, and none are anticipated for FY14 through FY18.

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 extrapolated from paid-claim data for used to prepare the CMS 372 report for FY11. Medicaid expenditures for psychiatric hospitalization (at Hawthorn) for FY11 were trended forward at a growth rate of 1.35% for Waiver Years 1 through 5 of the 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 extrapolated from paid-claim data used to prepare the CMS 372 report for FY11. The estimated annual average per capita cost to Medicaid for all other services provided to individuals while the individual was in a psychiatric hospital was trended forward at a growth rate of 1.35% for Waiver Years 1 through 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	

Waiver Services	
Community Transition	
Family Home Care Training	
Family Support and Training	
Home Care Training, Non-Family	
Therapeutic Activities	
Therapeutic Overnight Camping	
Wraparound	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**1912627.20**
Respite	☐	15 minutes	283	1056.00	6.40	**1912627.20**	
Child Therapeutic Foster Care Total:							**23100.00**
Child Therapeutic Foster Care	☐	day	5	42.00	110.00	**23100.00**	
Community Living Supports Total:							**1043328.00**
Community Living Supports	☐	15 minutes	228	715.00	6.40	**1043328.00**	
Community Transition Total:							**30550.00**
Community Transition	☐	one time only	47	1.00	650.00	**30550.00**	
Family Home Care Training Total:							**122850.00**
Family Home Care Training	☐	session	117	7.00	150.00	**122850.00**	
Family Support and Training Total:							**309680.00**
Family Support and Training	☐	session	79	49.00	80.00	**309680.00**	
Home Care Training, Non-Family Total:							**184966.11**
Home Care Training, Non-Family	☐	session	331	9.00	62.09	**184966.11**	
Therapeutic Activities Total:							**665.40**

GRAND TOTAL:	**6892406.71**
Total: Services included in capitation:	
Total: Services not included in capitation:	6892406.71
Total Estimated Unduplicated Participants:	**804**
Factor D (Divide total by number of participants):	**8572.65**
Services included in capitation:	
Services not included in capitation:	8572.65
Average Length of Stay on the Waiver:	208

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Activities	☐	session	2	5.00	66.54	665.40	
Therapeutic Overnight Camping Total:							117600.00
Therapeutic Overnight Camping	☐	session	42	2.00	1400.00	117600.00	
Wraparound Total:							3147040.00
Wraparound	☐	day	712	13.00	340.00	3147040.00	
					GRAND TOTAL:		6892406.71
					Total: Services included in capitation:		
					Total: Services not included in capitation:		6892406.71
					Total Estimated Unduplicated Participants:		804
					Factor D (Divide total by number of participants):		8572.65
					Services included in capitation:		
					Services not included in capitation:		8572.65
					Average Length of Stay on the Waiver:		208

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							2304614.40
Respite	☐	15 minutes	341	1056.00	6.40	2304614.40	
Child Therapeutic Foster Care Total:							27720.00
Child Therapeutic Foster Care	☐	day	6	42.00	110.00	27720.00	
Community Living Supports Total:							1258400.00
Community Living Supports	☐	15 minutes	275	715.00	6.40	1258400.00	
Community Transition Total:							36400.00
Community Transition	☐	one time only	56	1.00	650.00	36400.00	
Family Home Care Training Total:							148050.00
Family Home Care Training	☐	session	141	7.00	150.00	148050.00	
					GRAND TOTAL:		8306707.69
					Total: Services included in capitation:		
					Total: Services not included in capitation:		8306707.69
					Total Estimated Unduplicated Participants:		969
					Factor D (Divide total by number of participants):		8572.45
					Services included in capitation:		
					Services not included in capitation:		8572.45
					Average Length of Stay on the Waiver:		208

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Support and Training Total:							**372400.00**
Family Support and Training	☐	session	95	49.00	80.00	**372400.00**	
Home Care Training, Non-Family Total:							**222965.19**
Home Care Training, Non-Family	☐	session	399	9.00	62.09	**222965.19**	
Therapeutic Activities Total:							**998.10**
Therapeutic Activities	☐	session	3	5.00	66.54	**998.10**	
Therapeutic Overnight Camping Total:							**142800.00**
Therapeutic Overnight Camping	☐	session	51	2.00	1400.00	**142800.00**	
Wraparound Total:							**3792360.00**
Wraparound	☐	day	858	13.00	340.00	**3792360.00**	
					GRAND TOTAL:		**8306707.69**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		8306707.69
					Total Estimated Unduplicated Participants:		**969**
					Factor D (Divide total by number of participants):		**8572.45**
					Services included in capitation:		
					Services not included in capitation:		8572.45
					Average Length of Stay on the Waiver:		208

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**2304614.40**
Respite	☐	15 minutes	341	1056.00	6.40	**2304614.40**	
Child Therapeutic Foster Care Total:							**27720.00**
Child Therapeutic Foster Care	☐	day	6	42.00	110.00	**27720.00**	
Community Living Supports Total:							**1258400.00**
					GRAND TOTAL:		**8306707.69**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		8306707.69
					Total Estimated Unduplicated Participants:		**969**
					Factor D (Divide total by number of participants):		**8572.45**
					Services included in capitation:		
					Services not included in capitation:		8572.45
					Average Length of Stay on the Waiver:		208

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Supports		15 minutes	275	715.00	6.40	1258400.00	
Community Transition Total:							36400.00
Community Transition		one time only	56	1.00	650.00	36400.00	
Family Home Care Training Total:							148050.00
Family Home Care Training		session	141	7.00	150.00	148050.00	
Family Support and Training Total:							372400.00
Family Support and Training		session	95	49.00	80.00	372400.00	
Home Care Training, Non-Family Total:							222965.19
Home Care Training, Non-Family		session	399	9.00	62.09	222965.19	
Therapeutic Activities Total:							998.10
Therapeutic Activities		session	3	5.00	66.54	998.10	
Therapeutic Overnight Camping Total:							142800.00
Therapeutic Overnight Camping		session	51	2.00	1400.00	142800.00	
Wraparound Total:							3792360.00
Wraparound		day	858	13.00	340.00	3792360.00	

GRAND TOTAL:	**8306707.69**
Total: Services included in capitation:	
Total: Services not included in capitation:	8306707.69
Total Estimated Unduplicated Participants:	**969**
Factor D (Divide total by number of participants):	**8572.45**
Services included in capitation:	
Services not included in capitation:	8572.45
Average Length of Stay on the Waiver:	208

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**2304614.40**
Respite	☐	15 minutes	341	1056.00	6.40	**2304614.40**	
Child Therapeutic Foster Care Total:							**27720.00**
Child Therapeutic Foster Care	☐	day	6	42.00	110.00	**27720.00**	
Community Living Supports Total:							**1258400.00**
Community Living Supports	☐	15 minutes	275	715.00	6.40	**1258400.00**	
Community Transition Total:							**36400.00**
Community Transition	☐	one time only	56	1.00	650.00	**36400.00**	
Family Home Care Training Total:							**148050.00**
Family Home Care Training	☐	session	141	7.00	150.00	**148050.00**	
Family Support and Training Total:							**372400.00**
Family Support and Training	☐	Session	95	49.00	80.00	**372400.00**	
Home Care Training, Non-Family Total:							**222965.19**
Home Care Training, Non-Family	☐	session	399	9.00	62.09	**222965.19**	
Therapeutic Activities Total:							**998.10**
Therapeutic Activities	☐	session	3	5.00	66.54	**998.10**	
Therapeutic Overnight Camping Total:							**142800.00**
Therapeutic Overnight Camping	☐	session	51	2.00	1400.00	**142800.00**	
Wraparound Total:							**3792360.00**
Wraparound	☐	day	858	13.00	340.00	**3792360.00**	

GRAND TOTAL:	**8306707.69**
Total: Services included in capitation:	
Total: Services not included in capitation:	8306707.69
Total Estimated Unduplicated Participants:	**969**
Factor D (Divide total by number of participants):	**8572.45**
Services included in capitation:	
Services not included in capitation:	8572.45
Average Length of Stay on the Waiver:	208

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**2304614.40**
Respite	☐	15 minutes	341	1056.00	6.40	**2304614.40**	
Child Therapeutic Foster Care Total:							**27720.00**
Child Therapeutic Foster Care	☐	day	6	42.00	110.00	**27720.00**	
Community Living Supports Total:							**1258400.00**
Community Living Supports	☐	15 minutes	275	715.00	6.40	**1258400.00**	
Community Transition Total:							**36400.00**
Community Transition	☐	one time only	56	1.00	650.00	**36400.00**	
Family Home Care Training Total:							**148050.00**
Family Home Care Training	☐	session	141	7.00	150.00	**148050.00**	
Family Support and Training Total:							**372400.00**
Family Support and Training	☐	Session	95	49.00	80.00	**372400.00**	
Home Care Training, Non-Family Total:							**222965.19**
Home Care Training, Non-Family	☐	session	399	9.00	62.09	**222965.19**	
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Therapeutic Activities	☐	session	3	5.00	66.54	**998.10**	
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Therapeutic Overnight Camping	☐	session	51	2.00	1400.00	**142800.00**	
Wraparound Total:							**3792360.00**
Wraparound	☐	day	858	13.00	340.00	**3792360.00**	

GRAND TOTAL:	**8306707.69**
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Services included in capitation:	
Services not included in capitation:	8572.45
Average Length of Stay on the Waiver:	208