



Medicaid and CHIP Operations Group

December 18, 2024

Meghan Groen
Senior Deputy Medicaid Director
Michigan Department of Health & Human Services
Behavioral Health and Physical Health and Aging Services
400 S. Pine Street
P.O. Box 30479
Lansing, MI 48933

RE: 1915(c) Michigan's Waiver for Children with Serious Emotional Disturbance Renewal
MI.0438.R04.00

Dear Meghan Groen:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to renew Michigan's Waiver for Children with Serious Emotional Disturbance for individuals with serious emotional disturbances ages 0-21 years who meet a hospital level of care. The CMS Control Number for the renewal is MI.0438.R04.00 and should be referenced on all future correspondence relating to this waiver renewal.

For this HCBS waiver, you have requested a waiver of 1902(a)(10)(B) of the Social Security Act to waive comparability of services. The waiver has been approved for a five-year period with an effective date of October 1, 2024.

This waiver will offer the following supports for waiver participants: Respite, Supports for Participant Direction Financial Management Services, Children's Therapeutic Family Care, Community Living Supports, Home Care Training – Family, Home Care Training - Non-Family, Overnight Health and Safety Support, Therapeutic Activities and Therapeutic Overnight Camp.

The following number of unduplicated recipients and estimates of average per capita cost of waiver services have been approved:

Waiver Year	C Factor Estimates	D Factor Estimates	D' Factor Estimates	G Factor Estimates	G' Factor Estimates
Year 1	969	\$5730.50	\$33236.00	\$153153.00	\$3602.00
Year 2	969	\$6624.35	\$38407.00	\$156982.00	\$3602.00
Year 3	969	\$6888.18	\$39943.00	\$160906.00	\$3785.00

Year 4	969	\$7184.93	\$41694.00	\$164929.00	\$3879.00
Year 5	969	\$7450.46	\$43202.00	\$169052.00	\$3976.00

This approval is subject to your agreement to serve no more individuals than those indicated in “C Factor Estimates” shown in the table above. If the state wishes to serve more individuals or make any other alterations to this waiver, an amendment must be submitted for approval. The state may renew the waiver at the end of the five-year period by providing evidence and documentation of satisfactory performance and oversight.

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

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state’s spending plan.

In accordance with 42 CFR 423.910, states submit Medicare Modernization Act (MMA) files to CMS to, among other things, ensure that dually eligible individuals have the correct cost sharing amounts for the Medicare Part D prescription drug coverage. Participants in 1915(c) waivers qualify for \$0 copays for Medicare Part D drugs. To ensure cost sharing is accurate, it is imperative that the state apply the “H” indicator on MMA file submissions for all Medicare-eligible participants in this waiver. This indicator is what initiates \$0 copays for Medicare Part D drugs. More information is in chapter 6 of the [MAPD State User Guide](#).

Thank you for your cooperation during the review process. If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Krystal Duffy at krystal.chatman@cms.hhs.gov or (410) 786-5235.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

cc: Keri Toback
Mark Halter
Lynell Sanderson

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

1. Major Changes

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

Michigan is removing Wraparound and Family Support and Training (Parent Support Partner) as SEDW services and transitioning these to State Plan services to increase access. Family Support and Training as defined in the 2019 SEDW application is a parent-to-parent peer service. MDHHS is pursuing the addition of a parent-to-parent peer service (Parent Support Partner) to the state plan as part of a SPA, and MDHHS would like to remove Family Support and Training from the SEDW in coordination with this change. This will not result in a loss of access to applicants or participants because waiver enrollees will still be able to access the parent-to-parent model via the state plan based upon becoming eligible for Medicaid through waiver enrollment.

The historical version of wraparound was delivered to waiver enrollees based upon the service being authorized via the SEDW. MDHHS is pursuing a state plan amendment to add Intensive Care Coordination with Wraparound as a new Target Group for Targeted Care Management to the state plan. This new service will encompass the historical best practices of wraparound as delivered through the SEDW but will also more clearly align with the components of Targeted Case Management (assessment, service planning, monitoring). This change will not lead to a loss of access for applicants or participants because waiver enrollees will be able to access Intensive Care Coordination with Wraparound via the state plan based upon being eligible for Medicaid through the waiver, and this change will also expand access for non-waiver enrollees by allowing for Medicaid eligible children and youth to access Intensive Care Coordination with Wraparound via the state plan regardless of waiver enrollment.

For Therapeutic Activities, Equine Therapy will be added under the service array. Providers of Therapeutic Activities will no longer be required to have full board certification before providing services. This will expand the provider network for these services and allow more beneficiaries to receive services. Providers would be required to be under the appropriate supervision while pursuing board certification to maintain a high quality of this service being provided.

Michigan is updating the name of "Children's Therapeutic Foster Care" to "Children's Therapeutic Family Care" and updating the service to the best practice model.

Michigan is changing eligibility language for Overnight Health and Safety Support to allow more beneficiaries to access this service.

Michigan is updating the assessment tools for the SEDW. The PECFAS and CAFAS will no longer be used statewide and will be transitioned to the MichiCANS. While the DECA will continue to be used in Michigan, SEDW eligibility determination will be updated to reflect utilization of the MichiCANS in replacement of the DECA, PECFAS, and CAFAS.

"Fiscal Intermediary" has been updated to "Financial Management Services" for consistency of language. The service specifications have not changed.

We aligned verification for staff credentialing from every 2 years to every 3 years to provide administrative consistency and efficiencies. Many of our waiver provider agencies provide services outside of the waiver and this aligns with their certification requirements.

PIHP/CMHSP site reviews has been changed from biennial to annual site reviews.

Conflict Free Access and Planning requirements have been included in the application surrounding beneficiary service planning activities and service provision.

Performance measures and sampling methodology has been updated in response to CMS feedback.

Since the last renewal in 2019, MDHHS went through a reorganization. The Medicaid Services Administration (MSA) who had responsibility for operations and payments went through a reorganization and is now the Behavioral and Physical Health and Aging Services Administration (BPHASA). Additionally, a new bureau was created with a focus on children's specialty behavioral health services at this time. The administration, operation, and oversight of the 1915(c) waivers is now shared across two bureaus: the Bureau of Specialty Behavioral Health Services (BSBHS) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). BPHASA and BCCHPS continue to operate under MDHHS. Throughout the waiver application, MDHHS will be used to collectively capture BPHASA and BCCHPS involvement with the SEDW.

Pursuant to Section 12006(a) of the 21st Century Cures Act, Michigan continues to actively pursue successful implementation of Electronic Visit Verification (EVV) within all applicable waivers and state plan services, including the SEDW, for in-scope Personal Care Services (as defined by the Cures Act) that require an in-home visit by a provider. Michigan has selected the Open Vendor model and has executed a contract with a vendor to provide a State sponsored EVV solution. Michigan's current contract allows providers to either use the State sponsored EVV solution as their primary method of EVV reporting, or an alternate

approved EVV systems. Michigan's EVV solution is designed to collect all 6 required data elements including the type of service performed, individual receiving the service, date of the service, location of the service delivery, individual providing the service, and the time the services begins and ends. Michigan's EVV system also includes a pre-billing component that supports only clean claims being successfully adjudicated/processed. The SEDW is scheduled to go-live with EVV implementation by September 2024, and MDHHS remains committed to ongoing compliance beyond that date. Current in-scope services for SEDW include Community Living Supports and Respite services.

The MDHHS transition plan includes waiver renewal webinars for the PIHPs and CMHSPs to cover updates and answer questions prior to implementation. Waiver Support Application (WSA) training will also continue.

MDHHS is not using funding from section 9817 of the American Rescue Plan Act of 2021 (ARP) for the implementation of the changes under this amendment. However, because MDHHS accepted section 9817 for other purposes within the broader department, MDHHS is still subject to the Maintenance of Eligibility requirements for the Medicaid program. MDHHS covers children from birth to 21 who are medically needy via the state plan via 435.322. This population is also included in the eligibility groups that may receive waiver services.

IN THE CURRENTLY APPROVED WAIVER APPLICATION, PARENT-TO-PARENT SUPPORT IS DESIGNED TO SUPPORT PARENTS/FAMILY OF CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES (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 MDHHS APPROVED CURRICULUM.

MDHHS IS PROPOSING REMOVING THIS SERVICE FROM THE WAIVER AND ADDING A SIMILAR SERVICE TO THE STATE PLAN. CMS APPROVED THIS NEW SPA FOR PARENT SUPPORT PARTNER SERVICES ON SEPTEMBER 19, 2024. THE NEWLY APPROVED SERVICE IS SIMILAR IN TERMS OF THE SCOPE AND TYPE OF THE INTERVENTION AND RELATED PROVIDER QUALIFICATIONS. THE ONLY CHANGE IS THAT THIS SERVICE IS NOW AVAILABLE TO CHILDREN WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES (IDD) IN ADDITION TO CHILDREN WITH SED. CHILDREN WHO ARE ENROLLED IN THE WAIVER WILL STILL BE ABLE TO ACCESS THIS SERVICE AS A STATE PLAN SERVICE.

IN THE CURRENTLY APPROVED WAIVER APPLICATION, WRAPAROUND IS A SERVICE THAT ENCOMPASSES CASE MANAGEMENT AND SERVICE PLANNING ACTIVITIES AND ALSO INCORPORATES WRAPAROUND BEST PRACTICES. THE SPECIFIC ACTIVITIES THAT ARE INCLUDED ARE COPIED BELOW. WHILE THE WRAPAROUND PLAN MAY INCLUDE NON-MENTAL HEALTH SERVICES (E.G. TRANSPORTATION, CHILD CARE, FOOD SECURITY), WRAPAROUND IN THE CURRENTLY APPROVED WAIVER APPLICATION DOES NOT INCLUDE REIMBURSEMENT OF THESE OTHER SERVICES.

- PLANNING AND/OR FACILITATING PLANNING USING THE WRAPAROUND PROCESS, INCLUDING AT LEAST ONE MONTHLY FACE-TO-FACE CONTACT;
- DEVELOPING AN IPOS UTILIZING THE WRAPAROUND PROCESS;
- LINKING TO, COORDINATING WITH, FOLLOW-UP OF, ADVOCACY FOR, AND/OR MONITORING OF SERVICES WITH THE WRAPAROUND
- COMMUNITY TEAM AND OTHER COMMUNITY SERVICES AND SUPPORTS; BROKERING WITH PROVIDERS OF SERVICES WITH THE ASSISTANCE OF THE WRAPAROUND COMMUNITY TEAM;
- ASSISTANCE WITH ACCESS TO OTHER ENTITLEMENTS; AND COORDINATION WITH THE MEDICAID HEALTH PLAN OR OTHER HEALTH CARE PROVIDERS.

MDHHS IS PROPOSING REMOVING THIS SERVICE FROM THE WAIVER AND ADDING A SIMILAR SERVICE TO THE STATE PLAN. MDHHS SPECIFICALLY SOUGHT STATE PLAN AUTHORITY THROUGH A NEW TARGETED

CASE MANAGEMENT TARGET GROUP TO IMPLEMENT INTENSIVE CARE COORDINATION WITH WRAPAROUND (ICCW). THE NEW TARGET GROUP WILL RECEIVE THE FOUR COMPONENTS OF TARGETED CASE MANAGEMENT (ASSESSMENT, DEVELOPMENT OF THE CARE PLAN, REFERRALS, AND MONITORING) BUT WILL ALSO RECEIVE THESE SERVICES AT A GREATER INTENSITY AND FREQUENCY THAN WHAT IS PROVIDED UNDER OTHER TARGET GROUPS. MDHHS WILL ALSO USE THE WRAPAROUND PLANNING PROCESS TO SUPPORT THE COMPLETION OF THE FOUR TARGETED CASE MANAGEMENT ACTIVITIES. THIS SERVICE IS SUBSTANTIALLY SIMILAR TO THE EXISTING WRAPAROUND SERVICE IN THE CURRENTLY APPROVED WAIVER APPLICATION BECAUSE ICCW (1) ENCOMPASSES CASE MANAGEMENT AND SERVICE PLANNING ACTIVITIES AND ALSO INCORPORATES WRAPAROUND BEST PRACTICES AND (2) DOES NOT INCLUDE THE REIMBURSEMENT OF OTHER NON-MENTAL HEALTH SERVICES. CHILDREN WHO ARE ENROLLED IN THE WAIVER WILL STILL BE ABLE TO ACCESS THIS SERVICE AS A STATE PLAN SERVICE.

ALL CHANGES AS A RESULT OF THIS WAIVER RENEWAL WILL BE COMMUNICATED IN WRITING TO THE PIHPS AND CMHSPS, IN ADDITION TO BEING COMMUNICATED VERBALLY THROUGH SCHEDULED WAIVER RENEWAL WEBINARS, PRIOR TO IMPLEMENTATION. MDHHS WILL WORK WITH THE PIHPS AND CMHSPS TO COMMUNICATE THESE CHANGES TO PARTICIPANTS AND ALSO UPDATE THE IPOS FOR BENEFICIARIES ACCORDINGLY.

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 section 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 Disturbance

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: MI.0438

Waiver Number: MI.0438.R04.00

Draft ID: ML.004.04.00

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

Regular Waiver

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

10/01/24

Approved Effective Date: 10/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and

75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under section 1915(b) of the Act.

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

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

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 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 section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

1115 Behavioral Health Waiver Demonstration

H. Dual Eligibility 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 purpose of the Waiver for Children with Serious Emotional Disturbance (SEDW) is to provide home and community-based services to children, youth, and young adults under age 21 who, if not for the availability and provisions of SEDW services, would otherwise require hospitalization in our state psychiatric hospital. The goal of the SEDW is to enable beneficiaries with serious emotional disturbance who have significant needs and who meet the SEDW eligibility requirements to live in their home and community instead of receiving hospital level of care. The objective is to provide regular Medicaid State Plan services and waiver services that address the participant's identified needs.

Waiver services include: Children's Therapeutic Family Care; Community Living Supports; Financial Management Services; Home Care Training, Family; Home Care Training, Non-Family; Overnight Health and Safety Support; Respite; Specialty Services (Music, Recreational, Art, and Equine Therapy); and Therapeutic Overnight Camp.

Oversight of the SEDW is provided by the Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. The administration, operation, and oversight of the 1915(c) waivers is shared across two teams: the Bureau of Physical Health and Aging Services Administration (BPHASA) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS), both which reside in MDHHS. The SEDW is a Managed Care program administered locally by Prepaid Inpatient Health Plans (PIHPs) under contract with MDHHS. Services are provided by the PIHP, its affiliate Community Mental Health Services Programs (CMHSPs) if applicable or its contracted entities. Services are provided directly by PIHPs, their contracted providers and/or providers of the beneficiary's choice through Financial Management Services under Choice Voucher arrangements and Purchase of Service contracts. When medically necessary, SEDW beneficiaries may receive any of the Mental Health State Plan services and waiver services identified in Appendix C of this §1915(c) renewal waiver application. Beneficiaries enrolled in the SEDW may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- | |
|--|
| <p>Yes. This waiver provides participant direction opportunities. Appendix E is required.</p> <p>No. This waiver does not provide participant direction opportunities. Appendix E is not required.</p> |
|--|
- 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 section 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 section 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. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):
- No
- Yes
- If yes, specify the waiver of statewide that is requested (*check each that applies*):
- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver

only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to section 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 inpatients 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:

Prior to decisions being made regarding changes for the 1915(c) waiver renewals, MDHHS solicited community partners and public feedback through a variety of avenues between May and December 2023. MDHHS presented at the Self-Determination Conference and Annual Waiver Conference. MDHHS also held a series of waiver feedback meetings with internal and external community partners. The meetings were widely distributed to invite multiple community/public groups, including MDHHS staff, PIHP/CMHSP staff, community partners, advocacy groups, and families. The goal of the feedback meetings was to discuss current waiver services, processes, and operations, and gather feedback on suggested changes to each of these areas. Feedback was also received through scheduled meetings with internal MDHHS staff and external partners, as well as via email on an ongoing basis. The consolidated feedback was discussed in depth with MDHHS waiver staff to begin drafting potential changes for the waiver renewal.

MDHHS sent a Tribal notice on 05/01/2024 to provide an opportunity for Tribal members to review the waiver applications and submit comments. The period of Tribal comment ended 06/17/2024. The general public notice/comment period was 05/17/2024-06/19/2024.

Non-electronic public notice:

Public notice was released via several of the major newspapers statewide on 05/17/2024. The newspaper notice included the website where the applications were posted as well as the email address and mailing address where comments and requests could be submitted.

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

<https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/medwaivers> Responses to specific comments are addressed below:

COMMENT: The extra 16 hours of training required for staff working with families on the waiver (in a Wraparound facilitator or Care coordination role) and supervisors is excessive. Children's staff are already required to receive 24 hours of children's specific training each year, not including this additional requirement.

RESPONSE: The requirement of 16 additional training hours is due to specialized nature of the program the acuity of children determined eligible for the waiver. Additional training is needed to support successful operations.

COMMENT: Is all Family Support and Training being removed or just Parent Support Partner?

RESPONSE: Thank you for your comment. Family Support and Training and Parent Support Partner is the same service. It will be removed from the SED Waiver as a service and will continue to be available to SEDW beneficiaries through the state plan.

COMMENT: Clarification requested regarding use of the DECA and MichiCANS and elimination of CAFAS/PECFAS.

RESPONSE: The MichiCANS will be replacing the CAFAS/PECFAS, to measure substantial functional limitations to support SEDW eligibility determination. DECA will be retained as the functional assessment tool for ages birth through age 5.

COMMENT: Regarding eligibility criteria, clarification is needed related to living independently with supports. Suggest adding additional language related to "living independently with supports."

RESPONSE: Thank you. We will take this recommendation under advisement for future MPM edits.

COMMENT: Clarification recommended regarding Medicaid eligibility as SEDW is a pathway to Medicaid OR individual may already have Medicaid.

RESPONSE: If a child/youth meets eligibility criteria for the SEDW, it is regardless of private/commercial insurance or Medicaid coverage. The SEDW serves as a pathway to Medicaid for children/youth who otherwise would not meet eligibility for Medicaid.

COMMENT: Regarding "When beneficiaries are enrolled in the SEDW, the child and family team develops measurable outcomes that guide the team toward transition or graduation from wraparound and enrolled waiver status," please clarify: Wraparound is no longer required for SEDW enrollees, correct?

RESPONSE: Wraparound is no longer a required service for the SEDW and is converting to ICCW effective 10/1/2024. SEDW children/youth are to be enrolled into ICCW as ICCW is the recommended model to support the child, youth, young adult and their family through the planning process. At the preference of the child/youth, young adult and their family, Targeted Case Management (TCM) may be utilized instead of ICCW.

COMMENT: Regarding "In order to provide an appropriate, adequate array of service providers, each PIHP establishes a

procurement schedule/process for contracting with direct service providers. In addition, PIHPs routinely expand their provider panel to meet the needs of SEDW beneficiaries and upon request of beneficiaries to add direct service providers.” This appears to address provider network adequacy. Should the language be more definitive to tie at a minimum the procurement schedule/process to the annual network adequacy process?

RESPONSE: Thank you. We will take this recommendation under advisement to ensure alignment with other requirement language addressing network adequacy.

COMMENT: Recommend clarifying throughout the document that all beneficiaries enrolled in the SEDW must be in an approved independent living setting, not just living independently with supports.

RESPONSE: Thank you. We will take this recommendation under advisement for future MPM edits.

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:

Behavioral and Physical Health and Aging Services Administration, Actuarial Division

Address:

400 South Pine St., 7th Floor

Address 2:

P.O. Box 30479

City:

Lansing

State:

Michigan

Zip:

48909

Phone:

(517) 284-1190

Ext:

TTY

Fax:

(517) 335-5007

E-mail:

ColemanJ@michigan.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Michigan

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

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

Signature:

Meghan Groen

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The requested effective date for removing Family Support and Training and Wraparound as covered waiver services is 10/01/2024. As both services will continue to be available to Waiver for Children with Serious Emotional Disturbance (SEDW) beneficiaries through the state plan, we do not anticipate a transition plan being necessary to support beneficiaries with this change.

For the PECFAS/CAFAS transition to MichiCANS, the timeline for implementation is 10/1/24. Prior to implementation, all PIHP/CMHSP staff will have received MichiCANS training and technical assistance. During the soft launch phase, several CMHSPs have already been utilizing the MichiCANS. The DECA will be use in conjunction with the MichiCANS at the point of initial and annual assessment for children, 1 month through 5, who are SED or SED/IDD. MDHHS is using the DECA and MichiCANS results to support eligibility decisions for the SEDW. The MDHHS SEDW team will be holding waiver renewal training meetings on a monthly basis beginning in July and continuing past October to fully inform and train the SEDW staff on waiver-related changes, including the MichiCANS. The Waiver Support Application will be updated to reflect the change from PECFAS/CAFAS scores to the MichiCANS. Current beneficiaries will be assessed with the MichiCANS at annual reassessment, and new beneficiaries be assessed using the MichiCANS during the initial assessment and eligibility determination for the waiver. MDHHS does not anticipate any current beneficiaries will experience a loss of or decrease in eligibility of services as a result of the implementation of the MichiCANS.

MDHHS created a Decision Support Model (DSM) associated with the SEDW eligibility criteria. The DSM was empirically tested, which means that national data was run through the DSM as well as local data through the clinical case review process. As part of the clinical case review process, current clinicians were also consulted to ensure that the DSM accurately accounted for SEDW eligibility. Also, once an applicant is deemed eligible under the SEDW, the covered waiver services are available to each SEDW beneficiary. If an SEDW beneficiary was receiving additional services outside the waiver such as state plan services, a loss of eligibility of those services is not anticipated. Decision Support Models were created for a subset of children’s specialty behavioral health services, which also followed the same process.

All changes as a result of this waiver renewal will be communicated in writing to the PIHPs and CMHSPs, in addition to being communicated verbally through scheduled waiver renewal webinars, prior to implementation.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

Michigan Department of Health and Human Services - Bureau of Physical Health and Aging Services
Administration and Bureau of Children's Coordinated Health Policy and Supports

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

a)The Michigan Department of Health and Human Services (MDHHS) is the Single State Medicaid Agency. Oversight of the Waiver for Children with Serious Emotional Disturbance (SEDW) is provided by the Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. The administration, operation, and oversight of the 1915(c) waivers is shared across two teams: the Bureau of Physical Health and Aging Services Administration (BPHASA) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS), both which reside in MDHHS. BPHASA and BCCHPS perform the following operational and administrative functions: all administrative functions related to the SEDW including review and approval of initial waiver applications submitted by Prepaid Inpatient Health Plans (PIHPs), waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS assurances, including financial accountability. Additionally, BPHASA and BCCHPS staff approve or certify some programs, disseminate information concerning the waiver to potential enrollees and service providers, assist individuals in waiver enrollment, manage waiver enrollment against approved limits, monitor waiver expenditures against approved levels, monitor level of care evaluation activities, conduct site reviews, conduct utilization management functions, determine waiver managed care average costs per unit, conduct training and technical assistance (including providing input for updating the Medicaid Provider Manual) concerning waiver requirements and implementation.

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

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

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

PIHPs are delegated the responsibility to perform the following functions: disseminating information concerning the waiver to potential enrollees; assisting individuals in applying for waiver enrollment; managing waiver enrollments within the PIHP's allocation; conducting level of care evaluation activities for recertifications; assuring participants have been given freedom of choice of providers and have consented to Waiver for Children with Serious Emotional Disturbance (SEDW) services in lieu of Institutional Level of Care; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the beneficiary's needs; conducting prior authorization or utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining, monitoring and managing the qualified provider network for managed care and SEDW services.

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency

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

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

Appendix A: Waiver Administration and Operation

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

The MDHHS is responsible for assessing the performance of the PIHPs in conducting waiver operational and administrative functions. MDHHS monitors PIHPs 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 MDHHS to the participating PIHPs for the Waiver for Children with Serious Emotional Disturbance (SEDW). The delegated functions included in the review protocol are: level of care evaluation; review of beneficiary service plans; prior authorization of waiver services; utilization management; and provider qualifications and enrollment. MDHHS manages enrollment against approved limits by reviewing, approving and processing applications and renewal certifications submitted by PIHPs and by processing terminations submitted by PIHPs.

Appendix A: Waiver Administration and Operation

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

Within MDHHS, the site review team monitors implementation of the §1915(c) Waiver for Children with Serious Emotional Disturbance (SEDW) by PIHPs. The site review team has responsibility for performing site reviews at each of the PIHPs. A full site review is completed with each PIHP on an annual basis. The site review team reviews a proportionate random sample of SEDW beneficiaries at each PIHP. Those reviews include clinical record reviews, administrative record reviews, home visits and beneficiary interviews using the Site Review Protocols. The protocols are derived from requirements of the Michigan Mental Health Code, Administrative Rules, federal requirements, and Medicaid policies. The site review team monitors SEDW activities/functions delegated to the PIHPs to assure that: 1) level of care evaluations and reevaluations are made in accordance with SEDW eligibility requirements; 2) individual plans of service (IPOS) meet the SEDW beneficiary's identified needs for services; 3) needed services are provided in the amount, scope and duration defined in the IPOS; 4) PIHP prior authorization and utilization management are in accordance with established policies and procedures; and 5) provider qualifications are current, and willing, qualified providers are available to meet SEDW beneficiary's needs and choice. The site review team also oversees quality improvement efforts and ongoing quality assurance by the PIHPs.

Within MDHHS, BCCHPS has responsibility for operation of the SEDW on a daily 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 level; providing training and technical assistance concerning waiver requirements; completing SEDW waiver renewal applications, amendments and CMS-372 reports for submission to CMS; reviewing and consulting with PIHPs when the site review team has identified issues related to delegated functions; monitoring health and welfare issues by way of recipient rights complaints, sentinel events, Medicaid fair hearing requests, and the use of restrictive or intrusive behavioral interventions.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care waiver eligibility 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 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

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

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="proportionate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input style="width: 100%; height: 30px;" type="text"/>

Performance Measure:

Number and percent of PIHPs that implement quality assurance/improvement activities as required by contract. Numerator: Number of PIHPs 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input style="width: 100%; height: 30px;" type="text"/>
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100%; height: 30px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="EQR"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="sampling methodology determined by EQR"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

Performance Measure:

Number and percent of completed Individual Plans of Service (IPOS) that reflect provider separation of service planning from service delivery. Numerator: Completed IPOS with that reflect provider separation of service planning from service delivery. Denominator: All completed IPOS.

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 = <input type="checkbox"/>
Other Specify: <input type="checkbox"/>	Annually	Stratified Describe Group: <input type="checkbox"/>
	Continuously and Ongoing	Other Specify:

		Proportionate random sample, 95% confidence interval.
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of PIHPs who have effective Administrative policies in place regarding HCBS compliance and monitoring processes. Numerator: PIHPS who have administrative policies regarding HCBS compliance and monitoring. Denominator: All PIHPS reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportionate random sample, 95% confidence interval."/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

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):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportionate random sample, 95% confidence interval."/>
	Other Specify: <input type="text"/>	

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: <input data-bbox="323 577 748 660" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="820 864 1241 947" type="text"/>

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual 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 beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

Interviews are also conducted with at least one beneficiary 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.

An additional strategy employed by MDHHS 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. One EQR Component addresses PIHP compliance to BBA requirements and is another method of discovery with performance expectations.

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 findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Results of the site reviews are also shared with the Quality Improvement Council, which may make recommendations for system improvements at the PIHPs in areas of non-compliance.

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Sub Group	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:

The following eligibility requirements must be met:

- 1) The child must meet current MDHHS criteria for admission to the state psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual; and
- 2) The child must live in a home or community-based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services. This may include living with their birth or adoptive parent, legal guardian, relative, foster home that is willing to care for the child, or living independently with supports; and
- 3) The child must demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the recommendations made by the Decision Support Model from the MichiCANS as supported by the informed clinical decision; and
- 4) The child must meet Medicaid eligibility criteria and become a Medicaid beneficiary; and
- 5) The child must be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, and continues to meet all non-age related eligibility criteria, the child can remain on the waiver up to their 21st birthday.

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:

Beneficiaries that are enrolled in the 1915(c) Waiver for Children with Serious Emotional Disturbance (SEDW) may continue to have mental health needs that will require planning on the part of the Child and Family 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 beneficiaries are enrolled in the SEDW, the child and family 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 beneficiary approaches his/her early adult years, the child and family team focus on planning for this period of transition. There are many factors that are considered during this time: housing, employment, vocational training or school status, emotional/behavioral health, and physical health and safety. During this time it is common to focus on the life domain areas that will impact the beneficiary'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 beneficiary and family identify and understand what services may be available following disenrollment from the waiver. If the beneficiary's disability impacts his/her ability to earn income, the team will work with the beneficiary to apply for Social Security benefit at age 18. The team will also work with the beneficiary to identify other entitlements that would assist the beneficiary post waiver. This is also the time that the team will explore what mental health needs the beneficiary may have after his/her 21st birthday and start that transition process with adult services. Whenever possible, the adult services staff are encouraged to become part of the child and family 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 beneficiaries are enrolled in the waiver, transition planning starts at intake and continues until the beneficiary successfully transitions. Transitions are very different for each individual, but the CMHSP assumes the responsibility that the beneficiary's needs are met post-SEDW. 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 beneficiaries enrolled in the waiver is part of a plan of service and the wraparound planning process and is individualized to each beneficiary. Many beneficiaries 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 planning will assist the beneficiary in making a smooth transition to adult mental health or community-based services, as needed.

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

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:

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

The PIHP/CMHSP is responsible for identifying potential SEDW enrollees and guiding them through the referral process. A family could also make a request for the SEDW directly to the PIHP. In this case, the PIHP 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. MDHHS will educate PIHPs on how to respond to direct requests for the SEDW. PIHPs intake/access will be made aware that the SEDW serves as a pathway to Medicaid for eligible beneficiaries, so when a beneficiary makes a specific request for the SEDW, the beneficiary is assessed and either approved or denied. In the event of a denial (regardless if a lesser intensive service is offered) the beneficiary is informed of appeal rights and provided notice of appeal.

Upon specific request for the SEDW, PIHPs/CMHSPs are contractually obligated to provide an SEDW eligibility assessment at no charge regardless of insurance status. When an individual is determined to be eligible for the SEDW an ICCW case manager meets with the family to discuss waiver specifics while orienting the family to the waiver. Upon agreement to proceed with enrollment in the SEDW waiver services initiate immediately. Waiver leads submit the formal SEDW application to the state in the Waiver Support Application (WSA) for final process/approval. When it is determined a child does not meet waiver eligibility criteria, the family is provided formal notice of denial and rights to Medicaid Fair Hearing, even if the consumer is not a Medicaid beneficiary. The same policy is adhered to across the state.

The waiver provides for entrance of all eligible participants through a two-tier process grounded in a Intensive Care Coordination with Wraparound (ICCW) model. When an individual is determined to be eligible for the SEDW by the CMHSP a referral is submitted to the PIHP. The PIHP 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 PIHP determines level of functional limitation using the Michigan Child and Adolescent Needs and Strengths (MichiCANS) tool. For those individuals meeting the LOC for the waiver, the PIHP discusses choice of waiver services over hospitalization with the family, completes a Waiver Certification and application for each candidate and submits it to MDHHS via the Waiver Support Application (WSA) for review, approval, and enrollment in the waiver.

MDHHS educates PIHPs on how to respond to direct requests for the SEDW. PIHPs intake/access will be made aware that the SEDW serves as a pathway to Medicaid for eligible consumers, so when a consumer makes a specific request for the SEDW, the consumer is assessed and either approved or denied. In the event of a denial (regardless if a lesser intensive service is offered) the consumer is informed of appeal rights and provided notice of appeal.

The MichiCANS Screener gathers limited information on the child/youth's and parents/caregivers' needs and strengths. Community Mental Health Service Programs (CMHSP) will use the Screener at the initial access point (before the intake assessment). Based on the results of the Screener, the CMHSP will either initiate a crisis response, refer the child for an intake assessment at the CMHSP, or refer the child for services outside of the CMHSP. Children's Services Administration (CSA) staff will collect information through the Screener on all youth entering foster care. CSA staff will not complete the Comprehensive at this time. If information gathered via the Screener indicates the youth should be referred to the CMHSP for services, the MichiCANS Screener will be provided to the local CMHSP Access Center to inform immediate decisions. CMHSP Access staff will review the MichiCANS Screener results from CSA and update the results if new information is available. CMHSP Access staff will not administer a duplicative Screener if CSA has already completed a Screener unless a circumstance warranting an additional Screener is identified. MichiCANS comprehensive will be completed annually and also will be updated when new information is learned about the child, youth and/or family that would impact/change the clinical interpretation of needs and strengths, or if the new information would impact/change the treatment plan

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*):

- Section 1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.

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

- No
- Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal post-eligibility rules under §1924 of the Act.*

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

Personnel with responsibility for conducting the LOC evaluation and reevaluation are Child Mental Health Professional (CMHP) as defined in the Michigan Medicaid Provider Manual. A CMHP is an individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech language pathologist, audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited-licensed professional counselor, or individual with a human services degree hired and performing in the role of CMHP prior to January 1, 2008. Note: If an individual was hired and performed the role of a CMHP prior to January 1, 2008 and later transfers to a new agency, their CMHP status will be grandfathered into the new agency. The initial evaluation and reevaluation of the beneficiaries LOC, as submitted by the PIHP, is reviewed and approved by the MDHHS SEDW program staff who are CMHP s or who are obtaining CMHP designation under direct supervision and co-signature of a CMHP.

- 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.

MICHIGAN IS UPDATING THE ASSESSMENT TOOLS FOR THE SEDW. THE PECFAS AND CAFAS WILL NO LONGER BE USED STATEWIDE AND WILL BE TRANSITIONED TO THE MICHICANS. WHILE THE DECA WILL CONTINUE TO BE USED IN MICHIGAN, SEDW ELIGIBILITY DETERMINATION WILL BE UPDATED TO REFLECT UTILIZATION OF THE MICHICANS IN REPLACEMENT OF THE DECA, PECFAS, AND CAFAS.

MDHHS CREATED A DECISION SUPPORT MODEL (DSM) ASSOCIATED WITH THE SEDW ELIGIBILITY CRITERIA. THE DSM WAS EMPIRICALLY TESTED, WHICH MEANS THAT NATIONAL DATA WAS RUN THROUGH THE DSM AS WELL AS LOCAL DATA THROUGH THE CLINICAL CASE REVIEW PROCESS. AS PART OF THE CLINICAL CASE REVIEW PROCESS, CURRENT CLINICIANS WERE ALSO CONSULTED TO ENSURE THAT THE DSM ACCURATELY ACCOUNTED FOR SEDW ELIGIBILITY. ALSO, ONCE AN APPLICANT IS DEEMED ELIGIBLE UNDER THE SEDW, THE COVERED WAIVER SERVICES ARE AVAILABLE TO EACH SEDW BENEFICIARY. IF AN SEDW BENEFICIARY WAS RECEIVING ADDITIONAL SERVICES OUTSIDE THE WAIVER SUCH AS STATE PLAN SERVICES, A LOSS OF ELIGIBILITY OF THOSE SERVICES IS NOT ANTICIPATED. DECISION SUPPORT MODELS WERE CREATED FOR A SUBSET OF CHILDREN'S SPECIALTY BEHAVIORAL HEALTH SERVICES, WHICH ALSO FOLLOWED THE SAME PROCESS.

THE MICHICANS SCREENER GATHERS LIMITED INFORMATION ON THE CHILD/YOUTH'S AND PARENTS/CAREGIVERS' NEEDS AND STRENGTHS. PRE- PAID INPATIENT HEALTH PLANS (PIHP) WILL USE THE SCREENER AT THE INITIAL ACCESS POINT (BEFORE THE INTAKE ASSESSMENT). BASED ON THE RESULTS OF THE SCREENER, THE PIHP WILL EITHER INITIATE A CRISIS RESPONSE, REFER THE CHILD FOR AN INTAKE ASSESSMENT AT THE PIHP, OR REFER THE CHILD FOR SERVICES OUTSIDE OF THE PIHP. CHILDREN'S SERVICES ADMINISTRATION (CSA) STAFF WILL COLLECT INFORMATION THROUGH THE SCREENER ON ALL YOUTH ENTERING FOSTER CARE. CSA STAFF WILL NOT COMPLETE THE COMPREHENSIVE AT THIS TIME. IF INFORMATION GATHERED VIA THE SCREENER INDICATES THE YOUTH SHOULD BE REFERRED TO THE PIHP FOR SERVICES, THE MICHICANS SCREENER WILL BE PROVIDED TO THE LOCAL PIHP ACCESS CENTER TO INFORM IMMEDIATE DECISIONS. PIHPACCESS STAFF WILL REVIEW THE MICHICANS SCREENER RESULTS FROM CSA AND UPDATE THE RESULTS IF NEW INFORMATION IS AVAILABLE. PIHP ACCESS STAFF WILL NOT ADMINISTER A DUPLICATIVE SCREENER IF CSA HAS ALREADY COMPLETED A SCREENER UNLESS A CIRCUMSTANCE WARRANTING AN ADDITIONAL SCREENER IS IDENTIFIED. MICHICANS COMPREHENSIVE WILL BE COMPLETED ANNUALLY AND ALSO WILL BE UPDATED WHEN NEW INFORMATION IS LEARNED ABOUT THE CHILD, YOUTH AND/OR FAMILY THAT WOULD IMPACT/CHANGE THE CLINICAL INTERPRETATION OF NEEDS AND STRENGTHS, OR IF THE NEW INFORMATION WOULD IMPACT/CHANGE THE TREATMENT PLAN

FOR JANUARY 1, 2025 THROUGH STATE SPENDING AND CMS NOTIFICATION OF CLOSE-OUT OF ARP SECTION 9817 FUNDING:

FOR NEW APPLICANTS, THE STATE WILL CONTINUE TO USE BOTH THE CURRENT/OLDER EVALUATION OF ELIGIBILITY INSTRUMENT AND THE NEW INSTRUMENT BUT IF THE RESULTS ARE DIFFERENT AND ONE INDICATES THAT THE APPLICANT IS ELIGIBLE, THE STATE WILL APPLY THE RESULTS THAT ESTABLISH THAT THE INDIVIDUAL IS ELIGIBLE. FOR PARTICIPANTS RECEIVING A REEVALUATION OF ELIGIBILITY, THE STATE WILL USE THE NEW INSTRUMENT BUT IF THE RESULTS INDICATE THAT A PARTICIPANT IS NO LONGER ELIGIBLE, THE STATE WILL USE AND APPLY THE RESULTS OF THE CURRENT/OLDER ELIGIBILITY INSTRUMENT.

- 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 beneficiaries determined eligible due to functional limitations identified by the MichiCANS, a further review is conducted to determine if the beneficiary meets criteria for admission to a psychiatric hospital. If a beneficiary appears to meet these criteria, a referral is made to the PIHP for information gathering, review, preliminary eligibility determination (including family choice of waiver services over hospitalization), and possible application to the Waiver for Children with Serious Emotional Disturbance (SEDW). The PIHP makes a preliminary eligibility determination for the SEDW based on the published eligibility criteria, completes the waiver application for each beneficiary and submits it to MDHHS via the Waiver Support Application (WSA) for review, final eligibility determination (including level of care evaluation), approval, and enrollment in the waiver.

Services commence immediately upon approval and enrollment in the SEDW as the PIHPs have access to real-time enrollment information via the WSA.

A description of the reevaluation process is as follows: The date of the initial SEDW enrollment is considered the reevaluation date. If the beneficiary continues to meet SEDW criteria and to require the services of the SEDW the PIHP submits a newly executed Waiver Certification form to MDHHS. The Waiver Certification must be completed and signed within 12 months of the initial SEDW enrollment date and must be submitted to MDHHS within 30 days of signature to maintain eligibility. The PIHP also submits an updated MichiCANS Decision Support Model determination to document that the beneficiary continues to meet SEDW eligibility criteria; proof of current Medicaid eligibility; update demographics (if there have been changes); and updated diagnosis information (including a brief but behavior specific comment supporting SEDW eligibility). MDHHS staff review, determine continued eligibility (including level of care reevaluation), approve the renewal application and complete and sign section 2 of the Waiver Certification form. A WSA auto-generated approval form is sent to the SEDW Lead for the beneficiary's file, and the Medicaid Policy office is notified that the beneficiary 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*):

Waiver for Children with Serious Emotional Disturbance (SEDW) enrollment data is maintained in the Waiver Support Application (WSA) and is used to identify beneficiaries coming up for reevaluation. The PIHP/CMHSP can access a report in the WSA that identifies when reevaluations are due for the beneficiaries they serve. PIHP must submit a reevaluation packet within 365 days of the previous year's certification, as stated above. MDHHS also monitors the statewide report to track past due reevaluations. If necessary, SEDW staff contact the PIHP and instruct them to provide either a recertification or 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 PIHP maintains beneficiary's clinical records that include the Waiver for Children with Serious Emotional Disturbance (SEDW) initial and reevaluation packets, along with supporting documentation. The MDHHS 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 LOC INITIAL DETERMINATIONS COMPLETED ACCORDING TO STATE POLICIES AND PROCEDURES. NUMERATOR = NUMBER OF LOC INITIAL DETERMINATIONS COMPLETED ACCORDING TO STATE POLICIES AND PROCEDURES. DENOMINATOR = NUMBER OF INITIAL DETERMINATIONS REVIEWED.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Proportionate Random Sample, 95% confidence interval
	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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

ON A QUARTERLY BASIS, A SAMPLE NUMBER AND PERCENT OF LOC RE-EVALUATIONS ARE REVIEWED TO ENSURE THAT AN APPROPRIATE DETERMINATION WAS MADE. Numerator: Number of LOC re-evaluations where an appropriate determination was made. Denominator: All LOC re-evaluations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text" value="binennial, state wide data gathered over a 2 year period"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual 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 beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

Interviews are also conducted with at least one beneficiary 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.

An additional strategy employed by MDHHS 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. One EQR Component addresses PIHP compliance to BBA requirements and is another method of discovery with performance expectations.

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 findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Results of the site reviews are also shared with the Quality Improvement Council, which may make recommendations for system improvements at the PIHPs in areas of non-compliance.

On an ongoing basis, customer service functions at the MDHHS and the PIHPs provide assistance to individuals with problems and inquiries regarding services. As part of customer services within MDHHS, the Waiver for Children with Serious Emotional Disturbance (SEDW) staff also handle multiple consumer phone and email inquiries per month and work with the consumer and PIHP to address the issues or concerns.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Waiver Certification Form is a double-sided form with three (3) areas for completion. The third section of the Waiver Certification form is the Family Choice Assurance section, and is to be completed by the beneficiary's parent or legal guardian. This section verifies that the care coordinator or case manager 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)/guardian(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 care coordinator or case manager, as witness to the parent or guardian's signature, also signs and dates the form. The parent/ guardian receives a copy of the signed Waver Certification 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 PIHP in the beneficiary's clinical record and an electronic copy by MDHHS in the beneficiary record in the WSA under the Documents tab.

Appendix B: Participant Access and Eligibility

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

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

The contract between MDHHS and PIHPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. Each PIHP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHPs 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 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.

MDHHS's contract with PIHPs requires that PIHPs comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency, 45 CFR 92.201 and Section 1557 of the Patient Protection and Affordable Care Act. PIHPs are expected to take reasonable steps to provide meaningful access to each individual beneficiary with limited English Proficiency, such as language assistance services, including but not limited to, oral and written translation. To take into consideration the special needs of beneficiaries with disabilities or LEP, PIHPs must ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids, such as and Teletypewriter/Text Telephone (TTY/TDY) and American Sign Language (ASL), and services are available upon request at no cost, and how to access those services as referenced in 42 CFR Parts 438.10(d)(3) and 438.10(d)(4).

All materials must be written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 6.9 grade level criteria). All materials must be in an easily understood language and format and use a font size no smaller than 12 point. All informative materials, including the provider directory, must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on their website, in a machine-readable file and format. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in their Region. Such materials must be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2000, Federal Register Vol. 65, August 16, 2000). All such materials must be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries must be informed of how to access the alternative formats.

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		
Supports for Participant Direction	Financial Management Services		
Other Service	Children's Therapeutic Family Care		
Other Service	Community Living Supports		
Other Service	Home Care Training, Family		
Other Service	Home Care Training, Non-Family		
Other Service	Overnight Health and Safety Support		
Other Service	Therapeutic Activities		
Other Service	Therapeutic Overnight Camp		

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:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Respite care services are provided to beneficiaries on a short-term basis because of the need for relief of those persons normally providing care. The purpose of respite care is to relieve the beneficiary's family from daily stress and care demands. "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). Decisions about the methods and amounts of respite are decided during the person-centered planning process and are specified in the individual plan of service. Paid respite care may not be provided by a parent or legal guardian of a CWP beneficiary.

Respite care can be provided in the following locations: the beneficiary's home or place of residence; home of a relative or family friend's home in the community; Licensed Foster Family Home; Licensed Foster Family Group Home; Licensed Children's Camp; Licensed Children's Therapeutic Group Home.

Federal financial participation is not to 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.

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.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Children's Camp; Licensed Family Foster Home; Licensed Foster Family Group Home; Licensed Children's Therapeutic Group Home
Individual	Aide-level provider
Agency	PIHP or contracted 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:

Licensed Children's Camp; Licensed Family Foster Home; Licensed Foster Family Group Home; Licensed Children's Therapeutic Group Home

Provider Qualifications

License (*specify*):

All of these provider types are licensed under Public Act 116 of 1973, as amended [MCL 722.111, MCL 722.115-118(a), MCL 330.1153] and the Administrative Rules thereto.

Certificate (*specify*):

NA

Other Standard (*specify*):

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:

- At least 18 years of age;
- Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
- Able to perform basic first aid procedures;
- Trained in the consumer's individual plan of service (IPOS);
- Trained in recipient rights;
- Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Division of Child Welfare Licensing is the regulatory authority. MDHHS also verifies provider qualifications during regular and special investigation visits.

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications.

Frequency of Verification:

Licenses are issued/renewed for a two-year period. Providers of respite services are verified for meeting qualifications prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Aide-level 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. Aides must be:
 At least 18 years of age;
 Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
 Able to perform basic first aid procedures;
 Trained in the consumer's individual plan of service (IPOS);
 Trained in recipient rights;
 Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three 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:

PIHP or contracted provider

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-direction

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

A Financial Management Services (FMS) provider is an independent legal entity that acts as the fiscal agent of the PIHP for the purpose of assuring financial accountability for the funds authorized to purchase the services and supports identified in the beneficiary's plan of service. The FMS provider receives the funds; makes payments authorized by the beneficiary's representative to providers of services and supports; and acts as an employer agent when the beneficiary's representative directly employs staff or other service providers.

FMS includes, but is not limited to:

- a) Facilitation of the employment of service workers by the beneficiary's parent or guardian, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- b) Assuring adherence to federal and state laws and regulations; and
- c) Ensuring compliance with documentation requirements related to management of public funds.

The FMS provider may also perform other supportive functions that enable the consumer and his/her representative to self-direct needed services and supports. These functions may include helping the beneficiary recruit staff (e.g. developing job descriptions, placing ads, assisting with interviewing) – as requested by the beneficiary’s representative; contracting with or employing and directing providers of services; verification of provider qualifications (including reference and background checks); and assisting the beneficiary and his/her representative to understand billing and documentation requirements.

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

This waiver service is limited to beneficiaries who choose to self-direct services through Choice Voucher/Self Determination arrangements. The "unit" for this billable code is "per month" and can be billed once per month for beneficiaries using Choice Voucher/Self Determination arrangements.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications stated below
Agency	Financial Management Services Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Individual

Provider Type:

Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications stated below

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The individual must be contracted by the PIHP to provide FMS to CWP consumers. Additional qualifications include that the FMS provider:

1. Cannot be a provider of direct mental health services;
2. Cannot be a guardian or trust holder of any consumer or have any other compensated fiduciary relationship with a consumer (except representative payee);
3. Must be bonded and insured for an amount that meets or exceeds the total budgetary amount the FMS provider is responsible for administering;
4. Must have demonstrated ability to manage budgets and perform all functions of the FMS provider including all activities related to employment taxation, worker's compensation and state, local and federal regulations;
5. Must be able to fulfill the functions (which may include Employee Verification, Employer Agent, and/or Information and Guidance Functions) required by CMHSP as identified in the FMS Agreement;
6. Must have a positive track record of managing money and accounting;
7. Must be oriented to support and respond to each consumer or family with an individualized response;
8. Must be able to work with consumers to consider creative approaches both in payments and in arrangements (such as weekly payroll payments).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Management Services Agency

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

1. Provider must be bonded and insured.
2. Insured for an amount that meets or exceeds the total budgetary amount the FMS provider is responsible for administering.
3. Demonstrated ability to manage budgets and perform all functions of the FMS provider including all activities related to employment taxation, worker’s compensation and state, local and federal regulations.
4. FMS must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of an FMS provider.
5. Neither providers of other covered services to the participant, the family or guardians of the participant may provide FMS to the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Children's Therapeutic Family Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Children’s Therapeutic Family Care (CTFC) is an intensive community-based mental health service alternative to inpatient treatment facilities. It provides an intensive therapeutic living environment for children and youth with challenging behaviors. Important components of CTFC include:

- Family behavior treatment skills. Active participation of legal guardian or committed caregiver for the duration of services as a requirement of service eligibility.
- 24 hours per day, 7 days per week operation with on-call support from CTFC clinical team members.
- Treatment is temporary, typically 6-9 months.
- Positive adult-youth relationships. Therapeutic homes are required to meet all CMHSP health and safety requirements. Therapeutic parents are required to be credentialed as a contract provider. Therapeutic parents are recruited and highly trained individuals, who, as part of the team, assist in delivering CTFC using a prescriptive clinical model or Evidence Based Practice.
- Intensive parental supervision. Only one child or youth unrelated to the therapeutic parent can reside in the home and receive this service.
- Reduced contact with children with challenging behaviors
- CTFC is voluntary; permission for services is required from the child/youth legal guardian.

CTFC seeks to change the negative trajectory of a child’s behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. CTFC is designed to provide an intensive therapeutic living environment with a highly trained team of specialists.

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

CTFC must be billed as a 'per diem' service, up to a maximum of 365 days per year.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Children's Therapeutic Family Care

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License (specify):

The CTFC clinical team consists of 3 Master's prepared clinicians: 1 Lead Clinician; 1 Child Clinician; and 1 Family Clinician. Master's prepared clinicians must meet licensing requirements for their area of practice in the State of Michigan and meet MDHHS provider qualifications for Children's Mental Health Professionals (CMHP).

Certificate (specify):

NA

Other Standard (specify):

As a part of the CTFC treatment team, Therapeutic Parents are required to be credentialed as a contract provider with the PIHP. Therapeutic Parent(s) must meet all credentialing standards; be trained in recipient rights; able to perform basic first aid and emergency procedures by method(s) determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

CTFC programs must also be certified by MDHHS every three years.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications.

Frequency of Verification:

Provider qualifications are verified prior to the delivery of services and every three 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 Â§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:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

CLS provides assistance to the family in the care of their child while facilitating the beneficiary's independence and integration into the community. The supports, as identified in the IPOS, are provided in the beneficiary'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. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary enabling them to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Community Living Supports includes:

- Assistance with skill development related to:
- Activities of daily living (such as personal hygiene);
- Household chores;
- Socialization;
- Improving communication and relationship-building skills; and
- Participation in leisure and community activities.
- Staff assistance, support and/or training with such activities as:
- Improving the beneficiary's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors;
- Non-medical care (i.e., not requiring nurse or physician intervention);
- Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence;
- Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.);
- Assisting the family in relating to and caring for their child;
- Attendance at medical appointments;
- Acquiring or procuring goods other than those listed as shopping and non-medical services.
- Reminding, observing, rewarding and monitoring of pro-social behaviors.
- Medication administration.
- Staff assistance with preserving the health and safety of the beneficiary in order that he may reside or be supported in the most integrated, independent community setting.

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973, or the waiver or state plan covered services.

The purpose of the Goods and Services is to promote individual control over and flexible use of the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and Services can be services, equipment or supplies not otherwise provided through either the HSW, the State Plan or 1915 (i)SPA that address an identified need through the person-centered planning process. Each item or service specified in the IPOS must identify the beneficiary has a need and does not have the funds to purchase the good or service and the good or service is not available through another source. Goods and Services must: 1. Increase independence, facilitate productivity, or promote, improve or maintain community inclusion and/or 2. Decrease the need for other Medicaid services and, 3. Be provided to, or directed exclusively toward, the benefit of the beneficiary, 4. Be identified through the person-centered planning process, is documented in the IPOS and meets the Goods and Services medical necessity criteria which identifies the need and demonstrates how the good or service will increase independence, productivity and community inclusion and 5. Be provided through a self-directed arrangement purchased through an individual budget. A goods and services item can include the purchase of a warranty may be included when it is available for the item and is financially reasonable. A good may also include the purchase of adaptive clothing. Adaptive clothing is specifically designed to accommodate the needs of beneficiaries who require specialized garments. These specialized garments aim to enhance comfort, dignity, promote independence and ease the burden of dressing. **COVERAGE OF THIS SERVICE IS LIMITED TO**

WAIVERS THAT INCORPORATE THE BUDGET AUTHORITY PARTICIPANT DIRECTION OPPORTUNITY.

Goods and services have a limit of \$2000 per year. However, this coverage may not be used for the following: 1. To acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle, 2. Services covered by third parties or services that are the responsibility of a non-Medicaid program/service, 3. Services already covered through Medicaid plan, EPSDT and/or 1915 (i)SPA, 4. Health related services, equipment and supplies, 5. Room and board (including rent and mortgage payments), 6. Vacation expenses (travel, lodging costs, etc.) for the beneficiary and any paid staff who accompany the beneficiary on vacation. 7. Academic tutoring or other services covered under the Rehabilitation Act or IDEA 8. Internet, cell phones, utilities and telephone purchase or costs 9. Any purchase that does not meet HCBS settings requirements 10. Service animals or cost of pet care 11. Expenses and/or costs of meals incurred 12. Items or services if the purchase, as determined by PIHP: a. leads to significant monetary gain for a beneficiary’s support person(s). b. provides the support person(s) with significant influence over the beneficiary; and/or c. constitutes a conflict of interest. As used herein, the term “support person” includes an individual’s spouse, children, parents, guardians, any person engaging in sexual activity with the individual, partners residing with the individual, and/or any person who provides paid services.

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

Up to 744 units (15 minutes) per month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide-level provider
Agency	PIHP or contracted provider

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:

Aide-level 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. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Care Training, Family

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Home Care Training, Family provides for training and counseling services for the families of beneficiaries. For purposes of this service, "family" is defined as the people who live with or provide care to a beneficiary on the waiver, and may include a parent or siblings. Family does not include individuals who are employed to care for the beneficiary. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the beneficiary at home.

Home Care Training, Family 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. All family training must be included in the beneficiary's individual plan of services and must be provided on a face-to-face basis.

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

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP or contracted provider
Individual	Clinical professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Care Training, Family

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

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 MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Service providers for Home Care Training, 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 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:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Care Training, Family

Provider Category:

Individual

Provider Type:

Clinical professional

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):*

[Empty box]

Other Standard (specify):

Service providers for Home Care Training, 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 service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of service and every three 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 Â§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:

[Empty box]

Sub-Category 1:

[Empty box]

Category 2:

[Empty box]

Sub-Category 2:

[Empty box]

Category 3:

[Empty box]

Sub-Category 3:

[Empty box]

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

This service provides coaching, training, supervision and monitoring of CLS staff by clinicians (i.e., licensed psychologist, Master’s level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the beneficiary’s POS, with focus on services designed to improve the beneficiary’s social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the beneficiary or others, or that cause property damage.

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

Up to 4 sessions per calendar month

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional
Agency	PIHP or contracted provider

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of service and every three 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:

PIHP or contracted provider

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 MDHHS as a PIHP or the agency must be contracted by the PIHP to provide the service.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Overnight Health and Safety Support

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Overnight Health and Safety Support is defined as the need for someone to be present to prevent, oversee, manage, direct, or respond to a beneficiary's disruptive, risky, or harmful behaviors, during the overnight hours. Overnight Health and Safety Support is indicated for a person who is non-self-directing, confused, has a cognitive impairment or whose physical functioning is such that they are unable to respond appropriately in an emergency. It is further indicated for beneficiaries who have inconsistency in, or an inability to, regulate sleep patterns. For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period. The need for Overnight Health and Safety Support must be reviewed and established through the person-centered planning process with the specific reasons for this service and what support activities will be provided.

Overnight Health and Safety Support may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident, including monitoring for non-life-threatening self-harm behaviors that require redirection.
- Service will allow beneficiary to remain at home safely after all other available preventive interventions have been undertaken, and the risk of injury, hazard or accident remains
- Assistance is needed with instrumental activities of daily living (IADLs) that cannot be pre-planned or scheduled
- The need is caused by a medical condition or the form of supervision required is medical in nature (i.e., wound care, sleep apnea, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.)

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

The following exceptions apply for Overnight Health and Safety Support:

- Payments for Overnight Health and Safety Support may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.
- The Overnight Health and Safety Support service cannot be provided in a licensed residential setting.
- If the beneficiary receiving Overnight Health and Safety Support demonstrates the need for CLS or Respite, the IPOS must document coordination of services to assure no duplication of services provision with Overnight Health and Safety Support.

It does not include friendly visiting or other social activities.

It is not available for medical needs beyond provider qualification requirements (aid level staff) for this service.

Is not available in anticipation of a medical emergency.

Is not available to prevent or control severely anti-social or aggressive recipient behavior.

Is not available for a person without a physical, cognitive, or memory impairment who has anxiety about being alone at night.

Is not an alternative to inpatient psychiatric treatment and is not available to prevent potential suicide or other life-threatening self-harm behaviors.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide-level provider
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Overnight Health and Safety Support

Provider Category:

Individual

Provider Type:

Aide-level provider

Provider Qualifications

License (specify):

NA

Certificate (specify):

NA

Other Standard (specify):

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
 At least 18 years of age;
 Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
 Able to perform basic first aid procedures;
 Trained in the consumer's individual plan of service (IPOS);
 Trained in recipient rights;
 Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Overnight Health and Safety Support

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License (*specify*):

NA

Certificate (*specify*):

NA

Other Standard (*specify*):

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:

- At least 18 years of age;
- Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
- Able to perform basic first aid procedures;
- Trained in the consumer's individual plan of service (IPOS);
- Trained in recipient rights;
- Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to 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 they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three 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 Â§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:

11 Other Health and Therapeutic Services

Sub-Category 1:

11130 other therapies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

A therapeutic activity 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 beneficiary to accomplish the goals identified in the IPOS. The IPOS ensures the beneficiary's health, safety and skill development and maintains the beneficiary in the community. 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 beneficiary and family. Therapeutic activities may include the following: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the IPOS. Services provided under Therapeutic Activities include music therapy, recreation therapy, art therapy, and equine therapy. HOME, COMMUNITY, CLINICAL OR VIRTUAL, OR A COMBINATION AS DETERMINED IN THE IPOS.

This waiver service does not replace those services available under the state plan. All medically necessary therapeutic services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Therapeutic Recreation Specialist, Music Therapist, Art Therapist, Equine Therapist
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Activities

Provider Category:

Individual

Provider Type:

Therapeutic Recreation Specialist, Music Therapist, Art Therapist, Equine Therapist

Provider Qualifications

License *(specify):*

An equine therapist must hold a current license in the State of Michigan as an occupational therapist, physical therapist, speech pathologist, clinical social worker, psychologist, or professional counselor. The equine therapist must have appropriate specialized training and experience and must deliver services within their scope of practice. Specialized training includes (but is not limited to) the following credentials:

- Certification by the American Hippotherapy Certification Board
- Certification by other MDHHS-approved certification boards
- Completion of documented coursework in an applicable training program that is administered by an accredited university and approved by MDHHS

Certificate *(specify):*

Therapeutic Recreation Specialist, Music Therapist, and Art Therapist are not required to be board certified to provide services in their field, but must have completed all educational coursework requirements and be under the appropriate supervision working toward board certification in their respective fields (Therapeutic Recreation Specialist: National Council for Therapeutic Recreation (NCTRC); Music Therapist: National Music Therapy Registry (NMTR); Art Therapist: Art Therapy Credentials Board (ATCB)).

Other Standard *(specify):*

Service providers must meet PIHP/CMHSP provider qualifications, including appropriate licensure/certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. The agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

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:

PIHP or contracted provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Therapeutic Overnight Camp

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

A group and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary’s IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Additional criteria:

- Camps are licensed by the Department of Health and Human Services (DHHS);
- The child’s IPOS includes Therapeutic Overnight Camp; and
- Camp staff is trained in working with children with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp;
- Additional costs for staff with specialized training with this population.

Coverage excludes:

- Room and board for the camp.

Wraparound Care Coordinators should assess the need on an individual basis. The conversation should include parent’s ability to cover or contribute to the cost of the items.

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

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Therapeutic Overnight Camp

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Overnight Camp

Provider Category:

Agency

Provider Type:

Therapeutic Overnight Camp

Provider Qualifications

License *(specify):*

Camps are licensed under Public Act 116 of 1973, as amended [MCL 722.111, MCL 722.115-118(a), MCL 330.1153] and the Administrative Rules thereto.

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:

The Division of Child Welfare Licensing is the regulatory authority. MDHHS also verifies provider qualifications during regular and special investigation visits.

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications.

Frequency of Verification:

Licenses are issued/renewed for a two-year period. Providers of respite services are verified for meeting qualifications prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

The PIHPs or their contracting agency are responsible for conducting case management functions and for the coordination of waiver services on behalf of waiver beneficiaries. Individuals performing case management functions must meet the requirements of a Child Mental Health Professional (CMHP) or be supervised by a CMHP.

Appendix C: Participant Services

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

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

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

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

- (a) Criminal history/background investigations are completed for all direct care aide-level staff, all clinicians and all other individuals providing waiver services – whether a contractor or an employee. PIHPs/CMHSPs and entities/individuals assisting beneficiaries using Choice Voucher arrangements perform the investigations prior to hiring aides to perform respite and CLS services and/or prior to contracting with clinical service providers.
- (b) The PIHP/CMHSP or its contracted provider agency is responsible for conducting a search that reveals information substantially similar to information found on 1) an Internet Criminal History Access Tool (ICHAT) check, 2) a national and state sex offender registry check, or 3) OIG checks.
- (c) The Michigan Medicaid Provider Manual and the Michigan Mental Health Code state that staff must be in good standing with the law. The definition of "be in good standing with the law" means the person is 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. Criminal history/background investigations must be saved in the employee's personnel file. The annual site review process is the mechanism for ensuring that mandatory background checks have been completed.

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):

- (a) Another administration under MDHHS maintains a central registry. The PIHP or its contracted provider agency is responsible for completing the abuse registry screenings. PIHPs and entities/individuals assisting beneficiaries using Choice Voucher arrangements perform the screenings prior to hiring staff and/or contracting with providers.
- (b) Abuse registry screenings are completed for each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns) who under the PIHP contract works directly with children. PIHPs and entities/individuals assisting consumers using Choice Voucher arrangements perform the screenings prior to hiring aides to perform respite and CLS services and/or prior to contracting with clinical service providers.
- (c) Abuse registry screenings must be saved in the employee's personnel file.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

Other policy.

Specify:

Michigan does not allow payments to legal guardians or to relatives who are legally responsible for providing services to the beneficiary. 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.

Whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the person must meet the provider qualifications that apply to a service and there must be a properly executed provider agreement. In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply. The number of hours a relative may be authorized to provide would be the same level as hired staff. A relative that would not otherwise provide service without payment can provide CLS or respite. Michigan does not pay guardians to provide services.

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 MDHHS as a Community Mental Health Service Program (CMHSP), and can enroll with Medicaid as a PIHP/CMHSP. Waiver contract language requires Michigan’s PIHPs/CMHSPs to assure sufficient service capacity to meet the needs of CWP recipients. In addition, PIHPs/CMHSPs routinely expand their provider panel to meet the needs of CWP consumers and upon request of consumers to add direct service providers. The PIHP is the Provider of services. Individuals are given a choice of direct service providers that contract with the PIHP/CMHSP. If the family identifies a qualified provider, they refer that provider to the PIHP/CMHSP to become affiliated with the PIHP/CMHSP. Qualified providers chosen by the beneficiary should be placed on the provider panel.

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

At time of enrollment in the CWP case managers inform parents/legal guardians of their right to choose among the various waiver services and their right to choose among subcontracted providers.

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 enrolled consumers sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1249 1260 1335" type="text"/>
Other Specify: <input data-bbox="408 1473 646 1559" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1473 1260 1559" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1697 1260 1877" type="text"/> Proportinate random sample, 95% confidence level
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of providers 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 enrolled consumers sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

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

b. Sub-Assurance: The State 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 sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: proportionate random sample, 95% confidence level
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
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 sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1126 1264 1205" type="text"/>
Other Specify: <input data-bbox="408 1350 646 1429" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1350 1264 1429" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1574 1264 1753" type="text" value="proportionate random sample, 95% confidence level"/>
	Other Specify: <input data-bbox="719 1888 954 1966" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual 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 beneficiaries served by Michigan’s Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

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 findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Results of the site reviews are also shared with the Quality Improvement Council, which may make recommendations for system improvements at the PIHPs in areas of non-compliance.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

After conducting an initial review of settings under this waiver program, MDHHS determined that all settings under this waiver should be presumed to be compliant with the rule. All children under this waiver program are served in family homes, independent living settings, or foster family homes, as such all settings under this waiver were determined to meet the settings criteria. THE STATE OF MICHIGAN LICENSING RULES GOVERNING CHILD FOSTER FAMILY HOMES AND GROUP FOSTER FAMILY HOMES TO ENSURE THAT THE CHILDREN PLACED IN THESE SETTINGS ARE TREATED THE SAME AS ANY OTHER CHILDREN IN THE HOME AND THAT THE LICENSING RULES FULLY COMPORT WITH 42 CFR §441.301(C)(4). DUE TO THE CHARACTERISTICS OF THESE SETTINGS AND THE REQUIREMENTS UNDER STATE LICENSING, MDHHS HAS DETERMINED THAT THESE SETTINGS MEET THE REQUIREMENTS OF THE RULE. BASED ON THE 01/09/2015 CONFERENCE CALL BETWEEN MICHIGAN STAFF, RALPH LOLLAR AND MINDY MORRELL IT WAS DETERMINED THAT ALL SETTINGS (INCLUDING FOSTER FAMILY HOMES AND THERAPEUTIC CAMPS) FOR SEDW ARE CONSIDERED COMPLIANT TO THE FEDERAL HCB SETTINGS REQUIREMENTS. DURING THIS CONFERENCE CALL, CMS REQUESTED THAT MICHIGAN AMEND THE SEDW TRANSITION PLAN TO REFLECT THE FACT THAT FOSTER FAMILY HOMES AND ANY OTHER SETTING, PER LICENSING RULES, MEET THE HCBS REGULATORY REQUIREMENTS. CMS APPROVED THE AMENDED PLAN INCLUDING THE SEDW TRANSITION PLAN ON 03/27/2015. IF THE LICENSING REGULATIONS CHANGE, MICHIGAN WILL ENSURE THAT ALL CHILDREN ON THE SEDW ARE LIVING IN A PRIVATE HOME. MDHHS WILL NOT BE ASSESSING INDIVIDUAL SETTINGS UNDER THIS PROGRAM.

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)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Care coordinators must possess a bachelor's degree in any field and be a CMHP or be supervised by a CMHP. A CMHP is defined as a person who is trained in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed professional counselor, licensed or limited licensed marriage and family therapist or registered professional nurse;

or

A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained in the examination, evaluation, and treatment of minors and their families;

Or

A person with at least a master's degree in a mental health-related field from an accredited school who is trained in the examination, evaluation, and treatment of minors and their families.

The PIHPs have responsibility utilization management and for development and monitoring person-centered service plans and the network's implementation of the SEDW services, which require additional conflict of interest protections including separation of service planning and service delivery to align with the MDHHS approved CFA&P scenarios, as outlined in MDHHS CFA&P requirements and PIHP contracts.

In rural and or tribal communities and as outlined in MDHHS' Conflict Free Access and Planning "only-willing and qualified provider designation" process and approved by CMS, the State may approve an entity to provide both service planning and direct waiver services to the same beneficiary. In those limited circumstances and as defined in MDHHS' "only-willing and qualified provider designation" process the entity must implement protections to mitigate conflict of interest.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

THE STATE HAS CHOSEN TO LEVERAGE THE OPTION OF ALLOWING FOR ONLY WILLING AND QUALIFIED ENTITIES TO PROVIDE DIRECT SERVICES AND PERFORM ASSESSMENT AND PLANS OF CARE IN A GEOGRAPHICAL AREA. WHEN PROVIDERS OF DIRECT SERVICE ARE GIVEN RESPONSIBILITY TO PERFORM ASSESSMENTS AND PLANS OF CARE, THEY MUST BE THE ONLY WILLING AND QUALIFIED ENTITY IN A GEOGRAPHICAL AREA. THE ONLY WILLING AND QUALIFIED PROVIDER (OWQP) DESIGNATIONS ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:

1A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA

1B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TO INDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES TRIBAL PROVIDERS)

2: PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS

3: PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES "LACK OF OTHER DIRECT SERVICE PROVIDERS")

THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED. CONFLICT OF INTEREST PROTECTIONS: MDHHS IS RESPONSIBLE FOR IDENTIFYING QUALIFIED PROVIDERS TO RECEIVE A OWQP DESIGNATION USING CLEAR AND PUBLISHED SET OF CRITERIA. MDHHS FACILITATES THE OWQP DESIGNATION PROCESS EVERY THREE YEARS. MDHHS DEFINES THE CRITERIA FOR OWQP DESIGNEES, COMPLIANCE EXPECTATIONS AND REQUIREMENTS, INCLUDING ACCEPTABLE SAFEGUARDS TO LIMIT CONFLICTS OF INTEREST. MDHHS WILL DIRECTLY OVERSEE AND MONITOR OWQP DESIGNATIONS THROUGH STATE POLICY, MEDICAID PROVIDER MANUAL LANGUAGE, CONTRACT LANGUAGE, SITE REVIEWS, AUDITS, AND DATA ANALYSIS. MDHHS MONITORING WILL INCLUDE ONGOING EFFORTS TO EXPAND THE PROVIDER NETWORK TO MAXIMIZE CHOICE FOR BENEFICIARIES.

MDHHS CONDUCTS RETROSPECTIVE REVIEWS OF OWQP DESIGNATION APPLICATIONS FOR COMPLIANCE. 1. OWQP: PROVIDERS WITH MDHHS-APPROVED OWQP DESIGNATION MUST ESTABLISH AND ATTEST TO PROTECT AGAINST CONFLICTS OF INTERESTS. SAFEGUARDS REQUIRED FOR MDHHS-APPROVED OWQP DESIGNEES MUST INCLUDE, AT MINIMUM:

A. AN OPPORTUNITY FOR THE PARTICIPANT TO DISPUTE THE STATE'S ASSERTION THAT THE CASE MANAGEMENT ENTITY IS THE ONLY WILLING AND QUALIFIED PROVIDER THROUGH AN ALTERNATIVE DISPUTE RESOLUTION PROCESS; B. ANNUAL EVALUATION BY A STATE AGENCY; C. ADMINISTRATIVELY SEPARATE THE PLAN DEVELOPMENT FUNCTION FROM THE DIRECT SERVICE PROVIDER FUNCTIONS (INCLUDING OVERSIGHT BY SEPARATE SUPERVISORS); D. REQUIRE THE INDIVIDUAL CONDUCTING SERVICE PLANNING OR ELIGIBILITY/NEEDS ASSESSMENT IS NOT THE SAME INDIVIDUAL PROVIDING DIRECT SERVICE.

2. OVERALL STRUCTURE: MICHIGAN'S PROVIDERS, INCLUDING CMHSPS IN THEIR ROLE AS PROVIDER, MAY NOT OFFER BOTH SERVICE PLANNING AND DIRECT SERVICES TO THE SAME BENEFICIARY WITHOUT AN OWQP DESIGNATION. TO BE COMPLIANT WITH CONFLICT FREE ACCESS AND PLANNING (CFA&P) REQUIREMENTS, CMHSPS MUST ARRANGE THEMSELVES IN ONE OF TWO SCENARIOS OR RECEIVE AN OWQP DESIGNATION AS THE THIRD SCENARIO.

A. SCENARIO 1: THE CMHSP CONTRACTS OUT BOTH SERVICE PLANNING AND DIRECT SERVICE FUNCTIONS TO PROVIDERS. THE CMHSP MUST ENSURE THAT A MEMBER IS REFERRED TO PROVIDER A FOR SERVICE PLANNING AND A SEPARATE PROVIDER B FOR DIRECT SERVICES.

B. SCENARIO 2: THE CMHSP DIRECTLY OFFERS BOTH SERVICE PLANNING AND DIRECT SERVICES AND CONTRACTS WITH PROVIDERS FOR THESE FUNCTIONS. THE CMHSP MAY CONTINUE TO PROVIDE SERVICE PLANNING OR DIRECT SERVICES TO A SINGLE MEMBER BUT MUST ENSURE A MEMBER IS REFERRED TO A SEPARATE PROVIDER A TO CONDUCT THE REMAINING FUNCTION.

C. SCENARIO 3: SEE INFORMATION ABOVE ON OWQP DESIGNATION.

3. THE PIHPS DELEGATE THE RESPONSIBILITIES OF PLAN DEVELOPMENT AND MONITORING TO CMHSP, OR CONTRACTED PROVIDER CHOSEN BY THE INDIVIDUAL OR FAMILY.

4. OVERALL SAFEGUARDS: MDHHS REQUIRES SAFEGUARDS AT SEVERAL LAYERS TO PROTECT AGAINST CONFLICTS OF INTEREST. SAFEGUARDS ARE IMPLEMENTED TO DEFINE, IDENTIFY,

MITIGATE, AND MONITOR POTENTIAL OR ACTUAL CONFLICTS OF INTEREST.

A. MDHHS OVERSEES THE DEVELOPMENT OF IMPLEMENTATION PLANS TO ACCOMPLISH THE MDHHS ESTABLISHED SAFEGUARDS.

B. THE FOLLOWING SAFEGUARDS ARE IDENTIFIED IN CONTRACTS.

I. MDHHS CONTRACTS WITH PIHPS RESTRICTS THE ENTITY (I.E., CMHSP OR CONTRACTED PROVIDER) THAT DEVELOPS THE PERSON-CENTERED SERVICE PLAN FROM PROVIDING SERVICES WITHOUT THE DIRECT APPROVAL OF THE STATE.

II. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO MAINTAIN AND PUBLISH A COMPLETE PROVIDER DIRECTORY, INCLUDING INDEPENDENT FACILITATORS, IN HARD COPY AND WEB-BASED FORMATS. INFORMATION MUST BE UPDATED ON AN ONGOING BASIS TO MAINTAIN ACCURACY.

III. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO BE RESPONSIBLE FOR UTILIZATION MANAGEMENT OF SERVICES COVERED UNDER THE SCOPE OF CFA&P IMPLEMENTATION. THE PIHP CANNOT DELEGATE THEIR AUTHORIZATION AND UTILIZATION MANAGEMENT RESPONSIBILITIES TO OTHER ENTITIES.

IV. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO PROVIDE FULL DISCLOSURE TO BENEFICIARIES AND ASSURANCE THAT BENEFICIARIES ARE SUPPORTED IN EXERCISING THEIR RIGHT TO FREE CHOICE OF PROVIDERS AND ARE PROVIDED INFORMATION ABOUT THE FULL RANGE OF WAIVER SERVICES, NOT JUST THE SERVICES FURNISHED BY THE ENTITY THAT IS RESPONSIBLE FOR THE SERVICE PLAN DEVELOPMENT. EACH PIHP MUST MAINTAIN A PROVIDER NETWORK THAT ENABLES A BENEFICIARY TO CHOOSE FROM AMONG A RANGE OF AVAILABLE NETWORK PROVIDERS WITHIN THE PIHP. EACH PIHP MUST HAVE A CUSTOMER SERVICES UNIT THAT WILL PROVIDE THE BENEFICIARY WITH INFORMATION ABOUT THE CHOICE OF SEDW PROVIDERS AND SERVICE ARRAY (CUSTOMER SERVICE STANDARDS POLICY) INITIALLY AND ANNUALLY OR THE BENEFICIARY MAY CHOOSE A SELF-DETERMINATION ARRANGEMENT (MDHHS/PIHP CONTRACT; SELF-DIRECTED SERVICES TECHNICAL REQUIREMENTS).

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.

Michigan uses a Person-Centered Planning/Family-Driven Youth-Guided Planning approach that encompasses the belief that the family is at the center of the planning process and the service providers are collaborators. The care coordinator orients that family to the SEDW including education regarding the SEDW, education regarding the wraparound process, right to choose among qualified providers, right to choose among the various waiver services, information about the development of the IPOS and wraparound plan. The wraparound process is an individualized, needs-driven, strengths-based process for beneficiaries and families with multiple needs and multiple system involvement. The Child and Family Team includes the family and those persons most familiar with the beneficiary and family selected by the family, plus service providers and community members. Team members are typically the parents, 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; needs assessment; developing a wraparound plan that is family-centered; developing crisis and safety plans; implementation of the wraparound plan; accessing informal and formal supports/resources; monitoring services/supports for effectiveness; evaluating individual/family outcomes identified by the family on a regular basis; pledging unconditional commitment to care; 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 beneficiary and family decide which individuals should be included to participate on the child and family team.

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-Driven Youth-Guided Planning 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 beneficiaries and families with multiple needs. 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 beneficiary 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. 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 beneficiary and family. It is the role of the care coordinator 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 beneficiary, family and team member; and focus on the beneficiary, 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 beneficiary participates in planning for services, as minors, they cannot 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 beneficiary, 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 ensure the safety of the beneficiary 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 an IPOS and provide on-going oversight, with the care coordinator or other qualified provider chosen by the beneficiary taking the lead responsibility. The Child and Family Team must review the IPOS frequently, at least every 12 months formally, but typically quarterly and as needs change. Revisions must be reflected in the wraparound plan and IPOS, and Child and Family Team minutes. The IPOS is signed by the parents, team members and care coordinator at time of plan finalization and after each formal plan review.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Although a beneficiary participates in planning for services, as minors, they cannot direct services or service providers. As noted above, all individual plans of care include crisis and/or safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The beneficiary and the family define the "crisis". The Crisis Plan provides for around-the-clock response in the community (24 hours per day, 7 days per week) and includes a safety plan that is intended to ensure the safety of the beneficiary 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 beneficiary's history to identify triggers of crisis. For example, a crisis might be brought on by new situations, a new routine, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the beneficiary 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.

All beneficiaries enrolled in the SEDW are living with their birth or adoptive parents, legal guardian, foster parents, or living independently with supports. Waiver services include active treatment, training, and support to the beneficiary and relief for parents. The SEDW standards include requirements that staffing meets the beneficiary's identified needs as outlined in the beneficiary's IPOS. Crisis and safety plans must identify when a beneficiary's well-being could be jeopardized when a care provider fails to show up or is unable to provide services. The IPOS must include a written plan for families to follow when issues such as provider no-shows arise; and the written plan must identify provisions for alternate arrangements for staffing services that are critical to beneficiary's well-being. While the PIHP is ultimately responsible for assuring that services identified in the IPOS are provided at a level that meets the beneficiary's needs, this responsibility initially rests with the entity providing staff, as identified in the contract with the PIHP (e.g., contractual staffing agencies).

The PCP process is the main method through which issues related to risk are identified, strategies for mitigating risk are developed, and methods for monitoring are determined. This process is described below in detail and it is effective because it involves the people most trusted and valued by the beneficiary, including family, friends and other allies. The process is an open one in which the pros and cons of alternatives can be discussed. In this manner, health and welfare issues are balanced with the beneficiary's right to make his or her own choices. Solutions to these health, safety and welfare issues are brought up, discussed and resolved to assure the health and welfare of the beneficiary in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction. In the person-centered planning process, the beneficiary is informed of identified potential risk(s) to enable the beneficiary to make informed decisions and choices with regard to these risks. Often the discussion leads to better alternatives that both meet the beneficiary needs and satisfy his or her dreams and goals. A beneficiary may choose to address a sensitive health and welfare issue privately with the supports coordination provider, rather than within the group PCP process. Regardless of how it is done, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) has an obligation to ensure that all health and welfare issues are addressed. When the beneficiary makes a decision contrary to the recommendation of a member of his or her circle of support, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) must ensure that the beneficiary has information about all available options, documents the beneficiary choice, and revisits the issue as needed. Sometimes, a beneficiary's choices about how their supports and services are provided cannot be supported by the HSW because the choices pose an imminent risk to the health and welfare of the beneficiary or others. However, these decisions are made as part of the planning process in which the beneficiary and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the beneficiary's needs and satisfy their dreams and goals. Beneficiary-approved risk strategies are documented and written into the IPOS. Beneficiaries may be required to acknowledge situations in which their choices pose risks for their health and welfare. If the documented health or safety needs of an individual require restrictive interventions (modifications of the HCBS rule) this process will occur in the Person-Centered Planning meeting. All restrictive interventions will be written into the individual POS consistent with the requirements specified by the HCBS Final Rule and consistent with the HCBS chapter in the Medicaid Provider Manual. Back-up plans provide alternative arrangements for the delivery of services that are critical to beneficiary well-being in the event that the provider responsible for

furnishing the services fails to or is unable to deliver them. A copy of the backup plan should be provided to the beneficiary, left in the beneficiary's home, included in the beneficiary's case record, and given to applicable service providers. Back-up plans include developing lists of alternative qualified providers, using a provider agency, using informal supports, or alerting/contacting the supports coordinator when planned for services are not available. Additionally, emergency plans are developed for each beneficiary that clearly describes a course of action when an emergency situation occurs with the beneficiary. Plans for emergencies are discussed and incorporated into the IPOS during the PCP process. In an effort to make improvements in the way back-up plans are developed with beneficiaries, agencies must monitor and track situations in which back-up plans are activated, as well as when they are successful or unsuccessful. Although a beneficiary participates in planning for services, as minors, they cannot direct services or service providers. As noted above, all individual plans of care include crisis and/or safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The beneficiary and the family define the "crisis". The Crisis Plan provides for around-the-clock response in the community (24 hours per day, 7 days per week) and includes a safety plan that is intended to ensure the safety of the beneficiary 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 beneficiary's history to identify triggers of crisis. For example, a crisis might be brought on by new situations, a new routine, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the beneficiary 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. All beneficiaries enrolled in the CWP are living with their birth or adoptive parents, legal guardian, foster parents, or living independently with supports. Waiver services include active treatment, training, and support to the beneficiary and relief for parents. The SEDW standards include requirements that staffing meets the beneficiary's identified needs as outlined in the beneficiary's IPOS. Crisis and safety plans must identify when a beneficiary's well-being could be jeopardized when a care provider fails to show up or is unable to provide services. The IPOS must include a written plan for families to follow when issues such as provider no-shows arise; and the written plan must identify provisions for alternate arrangements for staffing services that are critical to beneficiary's well-being. While the PIHP is ultimately responsible for assuring that services identified in the IPOS are provided at a level that meets the beneficiary's needs, this responsibility initially rests with the entity providing staff, as identified in the contract with the PIHP (e.g., contractual staffing agencies).

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 PIHP to become a part of the PIHP provider network. Subsequent to the pre-planning meeting, once a beneficiary and family's needs are identified and prioritized, the 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 care coordinator or other qualified provider chosen by the beneficiary, continue to identify qualified providers from which the family may choose. The beneficiary and family choice drives the IPOS. This includes the beneficiary and family choice of qualified service providers from the PIHP 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 family's signature on the IPOS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

THE RESPONSIBILITY FOR APPROVING THE INDIVIDUAL PLAN OF SERVICES (IPOS) IS DELEGATED TO THE PIHPS. EACH PIHP DEVELOPS ITS OWN PROCESS THAT BY WHICH IT APPROVES THE IPOS THAT IS IN COMPLIANCE WITH CONFLICT FREE REQUIREMENTS AND MPM POLICY REQUIREMENTS. THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDES OVERSIGHT OF THE IPOS APPROVAL PROCESS AND QUALITY OF THE IPOS THROUGH ITS MDHHS SITE REVIEW PROCESS AND DURING THE SEDW INITIAL ENROLLMENT AND HSW RECERTIFICATION REVIEW. MDHHS RETROSPECTIVELY REVIEWS EVERY IPOS DURING THE ENROLLMENT AND RECERTIFICATION PROCESS. ONE HUNDRED PERCENT OF IPOS SUBMITTED DURING THE INTIAL ENROLLMENT PROCESS AND RECERTIFICATION PROCESS ARE REVIEWED BY MDHHS QIDP FOR COMPLIANCE. ANY DISCREPANCIES OR CONCERNS NOTED DURING MDHHS REVIEWS RESULTS IN TECHNICAL GUIDANCE BEING PROVIDED TO THE PIHP SEDW LEAD.

THE MDHHS SITE REVIEW TEAM CONDUCTS ANNUAL AUDITS FOR EACH PIHP TO ENSURE IPOS HAVE BEEN DEVELOPED IN ACCORDANCE WITH MDHHS PERSON- CENTERED PLANNING POLICY REQUIREMENTS, CONFLICT FREE REQUIREMENTS AND MPM POLICY REQUIREMENTS. ANY DISCREPANCIES OR CONCERNS NOTED DURING MDHHS REVIEWS RESULTS IN TECHNICAL GUIDANCE BEING PROVIDED TO THE CMHSP/PIHP AND REQUIRES CORRECTIVE ACTION TO AMEND THE IPOS TO MEET MDHHS POLICY AND STANDARDS AND REQUIRES SYSTEMIC REMEDIATIONS.

PLEASE REFER TO APPENDIX H-1.A.I. FOR FURTHER DETAIL ON THE REQUIRED SAMPLING METHODOLOGY FOR PERFORMANCE MEASURES RELATED TO THIS REQUIREMENT.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The PIHP is responsible for monitoring how the beneficiary implements services and supports, assuring that the funding is expended pursuant to the IPOS and individual budget and that risk management issues are addressed. The care coordinator will provide assistance to the beneficiary as requested or needed throughout the process of obtaining and implementing waiver services. The care coordinator must offer information and support to the beneficiary and directly address concerns that the beneficiary may have either over the phone or in a face-to-face meeting. The care coordinator must have face-to-face contact with the beneficiary at the frequency specified in the IPOS. The frequency of face-to-face visits should be determined based upon the beneficiary's preference, the beneficiary's health and welfare, and other circumstances identified for that beneficiary. Continued assistance is available throughout the time that the beneficiary receives services and supports. Beneficiaries and their allies contact the care coordinator when new needs emerge. The backup plan would be a crisis or safety plan, in the case the crisis/safety plan is needed. The care Coordinator additionally will coordinate State Plan Services that are not in the waiver.

IN THE ANNUAL SITE REVIEW PROCESS THE CLINICAL RECORDS ARE REVIEWED TO DETERMINE THAT CHILDREN/YOUTH/FAMILIES ARE AFFORDED THE CHOICE OF SERVICES AND PROVIDERS BY REVIEWING DOCUMENTATION OF SERVICE PLANNING. DURING THE IPOS/WRAPAROUND PLANNING PROCESS. THE PIHP IS RESPONSIBLE FOR MONITORING HOW THE BENEFICIARY IMPLEMENTS SERVICES AND SUPPORTS, ASSURING THAT THE FUNDING IS EXPENDED PURSUANT TO THE IPOS AND INDIVIDUAL BUDGET AND THAT RISK MANAGEMENT ISSUES ARE ADDRESSED. THE SUPPORTS COORDINATOR OR SUPPORTS COORDINATOR ASSISTANT, INDEPENDENT SUPPORTS BROKER, OR OTHER QUALIFIED PROVIDER AS SELECTED BY THE BENEFICIARY TO PROVIDE THESE FUNCTIONS) WILL PROVIDE ASSISTANCE TO THE BENEFICIARY AS REQUESTED OR NEEDED THROUGHOUT THE PROCESS OF OBTAINING AND IMPLEMENTING WAIVER SERVICES AND NON-WAIVER SERVICES. THE SC ALSO HAS A ROLE IN COORDINATING AND LINKING THE BENEFICIARY TO OTHER HEALTH SERVICES THAT MAY OR MAY NOT BE PROVIDED BY THE BEHAVIORAL HEALTH SYSTEM TO ENSURE THE BENEFICIARY IS RECEIVING ALL MEDICALLY NECESSARY SERVICES.

NEEDS ARE DETERMINED IN MEETINGS WITH THE CHILD/YOUTH/FAMILY, THE NEEDS ARE DEVELOPED TO REFLECT WHAT IS DRIVING THE BEHAVIOR. THE NEEDS ARE UTILIZED TO DETERMINE GOALS THAT WILL ASSIST THE CHILD/YOUTH/FAMILY ACHIEVE OUTCOMES. COORDINATORS MONITOR CASES BY UTILIZING THE FOLLOWING METHODS TO ENSURE THAT WAIVER AND NON-WAIVER SERVICES, AND ANY OTHER HEALTH RELATED SERVICES ARE DELIVERED AS SPECIFIED IN THE IPOS. THESE METHODS INCLUDE BUT ARE NOT LIMITED TO IN-PERSON VISITS, FACE TO FACE CONTACTS (AUDIO-VISUAL), EMAILS, PHONE CALLS, CONTACTS WITH FAMILY, SUPPORT CIRCLE OR PROVIDERS, LETTERS OR DOCUMENTATION REVIEW. THESE MONITORING METHODS WILL ENSURE BENEFICIARIES HEALTH AND WELFARE ARE ADDRESSED AT ALL TIMES, ARE ABLE TO EXERCISE THEIR FREEDOM OF CHOICE OF PROVIDERS, HAVE ACCESS TO ALL SERVICES (WAIVER, NON-WAIVER, HEALTH, ETC.), SERVICES PROVIDED MEET THE BENEFICIARY'S NEED, AND IDENTIFIED BACK-UP PLANS ARE EFFECTIVE IF NEEDED /IMPLEMENTED TO MEET THE BENEFICIARY NEEDS. THE METHODS UTILIZED WILL BE DETERMINED THROUGH THE PERSON-CENTERED PLANNING PROCESS BASED ON WHAT IS MOST EFFECTIVE FOR THE BENEFICIARY.

EMERGENCY AND CRISIS PLANS ARE DEVELOPED FOR EACH BENEFICIARY THAT CLEARLY DESCRIBES A COURSE OF ACTION WHEN AN EMERGENCY SITUATION OCCURS WITH THE BENEFICIARY. PLANS FOR EMERGENCIES ARE DISCUSSED AND INCORPORATED INTO THE IPOS DURING THE PCP PROCESS. IN AN EFFORT TO MAKE IMPROVEMENTS IN THE WAY BACK-UP PLANS ARE DEVELOPED WITH BENEFICIARIES, AGENCIES MUST MONITOR AND TRACK SITUATIONS IN WHICH BACK-UP PLANS ARE ACTIVATED, AS WELL AS WHEN THEY ARE SUCCESSFUL OR UNSUCCESSFUL.

THE COORDINATOR WILL COMMUNICATE WITH ALL SERVICE PROVIDERS, SYSTEM PARTNERS, AND ALL OTHERS INVOLVED WITH THE CHILD/YOUTH TO SUPPORT THE FAMILY THROUGH THE USE OF SAFETY PLANNING, REVIEWING OF PLANNING DOCUMENTS INCLUDING OUTCOMES AND STRATEGIES, AND MAKING ADJUSTMENTS TO MEET THE HEALTH AND WELFARE NEEDS OF THE CHILD/YOUTH/FAMILY. MONITORING FREQUENCY IS DETERMINED THROUGH THE PERSON-CENTERED PLANNING PROCESS AND AT A MINIMUM SHOULD BE PERFORMED ON A MONTHLY BASIS. THROUGH THE PERSON-CENTERED PLANNING PROCESS, BENEFICIARIES AND THEIR FAMILIES DETERMINE THEIR PREFERENCE AS TO WHETHER SERVICES ARE PROVIDED IN-PERSON OR VIA TELE-

HEALTH. IN-PERSON FACE-TO-FACE CONTACT MUST OCCUR AT A MINIMUM OF ONCE ANNUALLY

THE COORDINATOR WILL FACILITATE THE BROKERAGE OF SERVICES AND SUPPORTS AS IDENTIFIED THROUGH THE WRAPAROUND PLANNING PROCESS WITH ALL SYSTEMS THAT ARE INVOLVED WITH THE CHILD/YOUTH/FAMILY.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

To include an option for the participant to choose a different entity or individual to monitor the plan; MDHHS contract, Person-Centered Planning policy, and Self-Directed Services policy language requires PIHPs to publish a comprehensive and accessible provider directory, complete Medicaid service array, and beneficiary's rights including rights to acquire an Independent Facilitator and to engage Self-Directed Service Arrangements.

That direct oversight of the process; In addition to regular MDHHS auditing processes, PIHPs will be contractually required to monitor OWQP Designees to ensure they are implementing policies and procedures as intended. PIHPs may use authorization data, service plan audits, and grievance and appeals data to inform compliance with OWQP designations.

Regarding conducting an independent assessment of the effectiveness of monitoring or periodic evaluation by a state agency; MDHHS evaluates the effectiveness of PIHP's beneficiary enrollment and certification process which includes a review of the service plan and verification of compliance by the PIHP of these requirements.

In ongoing auditing processes, MDHHS reviews the approved implementation plan submitted by the PIHP for compliance. Additionally, MDHHS reviews clinical records in a site review process. MDHHS is developing reporting capabilities and integrating reporting into existing structures. That restrict the entity that develops the plan from monitoring services without the direct approval of the state; and Only CMHSPs/Providers with OWQP Designations may be responsible for service plan monitoring and direct services to the same beneficiary. Providers/CMHSPs with OWQP Designations must attest in their OWQP Designation application there is separation between staff offering service plan monitoring and staff offering direct services.

Additionally, the PIHPs, are responsible for utilization management functions, including authorization of the service plan.

That require that agency monitoring functions be administratively separate from service provision functions.

Providers/CMHSPs with OWQP Designations must attest in their OWQP Designation application there is separation between staff offering service plan monitoring and staff offering direct services. Methods to administratively separate service monitoring from direct service must be approved by MDHHS through the OWQP Designation application process.

PIHPs must verify and monitor the adequacy of the administrative separations outlined by the CMHSP/Providers in their OWQP Designation application.

WILLING-AND-QUALIFIED PROVIDER (OWQP) DESIGNATION: PROVIDERS WITH MDHHS-APPROVED OWQP DESIGNATION MUST ESTABLISH AND ATTEST TO ADDITIONAL SAFEGUARDS (INCLUDING THE SAFEGUARDS MENTIONED BELOW) TO PROTECT AGAINST CONFLICTS OF INTERESTS. SAFEGUARDS REQUIRED FOR MDHHS-APPROVED OWQP DESIGNEES MUST INCLUDE, AT MINIMUM: AN OPPORTUNITY FOR THE PARTICIPANT TO DISPUTE THE STATE'S ASSERTION THAT THERE IS NOT ANOTHER ENTITY OR INDIVIDUAL THAT IS NOT THAT INDIVIDUAL'S PROVIDER TO DEVELOP THE PERSON-CENTERED SERVICE PLAN THROUGH A CLEAR AND ACCESSIBLE ALTERNATIVE DISPUTE RESOLUTION PROCESS; DIRECT OVERSIGHT OF THE PROCESS OR PERIODIC EVALUATION BY A STATE AGENCY; ADMINISTRATIVELY SEPARATE THE PLAN DEVELOPMENT FUNCTION FROM THE DIRECT SERVICE PROVIDER FUNCTIONS; REQUIRE THE INDIVIDUAL CONDUCTING SERVICE PLANNING OR ELIGIBILITY/NEEDS ASSESSMENT IS NOT THE SAME INDIVIDUAL PROVIDING DIRECT SERVICE

THE ONLY WILLING AND QUALIFIED PROVIDER DESIGNATIONS ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:

1A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA

1B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TO INDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES

TRIBAL PROVIDERS)

2: PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS

3: PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES "LACK OF OTHER DIRECT SERVICE PROVIDERS") THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED.

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’s 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 sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="text"/>

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 sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% confidence level"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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 sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

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.

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 sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="proportinate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <input type="text"/>

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 within 365 days of their last plan of services. Denominator: All enrolled consumers sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% random sample"/>
	Other Specify:	

	<input style="width: 80%; height: 30px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

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 enrolled consumers sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

Number and percent of parents/guardians of enrolled consumers who are informed of their right to choose among providers. Numerator: Number of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers. Denominator: All enrolled consumers sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportinate random sample, 95% confidence level"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

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 enrolled consumers sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="proportinate random sample, 95% confidence levle"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual 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 beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

Interviews are also conducted with at least one beneficiary 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.

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 findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Results of the site reviews are also shared with the Quality Improvement Council, which may make recommendations for system improvements at the PIHPs in areas of non-compliance.

On an ongoing basis, customer service functions at the MDHHS and the PIHPs provide assistance to individuals with problems and inquiries regarding services. As part of customer services within MDHHS, the SEDW staff also handle multiple beneficiary phone and email inquiries per month and work with the beneficiary and PIHP to address the issues or concerns.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Michigan has a long history of supporting opportunities for participant self-direction. In the early 1990's, as one of the eight Community Supported Living Arrangements (CSLA) states, Michigan collaborated with youths of developmental disability services, their family members, advocates, providers, and other stakeholders to develop and operate a variety of Medicaid-funded services and supports pilots. These pilots were tightly governed under a values template of youth choice and control. In 1995, when the Congressional "sun" set on the federal CLSA program, all of the CSLA youths and as many of that program's self-directed features as the state was able to negotiate within its renewal were incorporated within this Waiver program. In 1996, the Michigan legislature made person centered planning a requirement for all participants receiving services and supports under the Mental Health Code.

Since 1997, when Michigan was awarded its Robert Wood Johnson Self-Determination demonstration grant, MDHHS has continued to build the demand and capacity for self-directed services. Elements of participant direction are embedded in both policy and practice from Michigan's Mental Health Code, the Department's Person-Centered Policy Practice Guideline and Self-Determination Policy and Practice Guideline, the contract requirements in the contracts between the state and the PIHPs, and technical assistance at the state level for multiple methods for implementation by the PIHP.

The Self-Directed Services Technical Requirements requires that PIHP/CMHSPs "must assure self-directed services are available to all beneficiaries, no matter where they live in Michigan and must actively assist beneficiaries that choose to self-direct youth" (page 1, Purpose). Moreover, the policy states "All person-centered planning processes, service delivery, and budget planning will support beneficiaries to make decisions about and control their own lives. This means the CMHSP/PIHP will actively commit to promoting Self-Direction and support the decisions beneficiaries who self-direct make about how to meet the goals of their IPOS within the parameters of the individual budget" (page 2 (12)). The nature of the opportunities afforded to adult SEDW or their representative if minors may elect employer authority or budget authority and can direct a single service or all of their services for which youth direction is an option. Resources to support the chosen youth-directed services are transferred to a Financial Management Services (FMS), which administers the funds and makes payment upon authorization of the youth's representative. Youths can directly employ staff or contract with clinical providers through Choice Voucher/Self Determination arrangements. The responsible parent of the SEDW beneficiary represents the common law employer of the providers of hourly care staff (until age 18) and directs clinical providers through purchase of service agreements. The responsible parent delegates performance of the fiscal/employer agent functions to the financial management service, which processes payroll and performs other administrative and support functions. The responsible parent of the SEDW beneficiary directly recruits, hires and manages service providers.

(a) How beneficiaries may take advantage of these opportunities

All beneficiaries served through specialty mental health are afforded the opportunity to self-direct their services. Beneficiaries have opportunities for both employer and budget authority. Beneficiaries may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. The beneficiary may direct the budget and directly contract with chosen providers. The individual budget is transferred to a financial management services provider which administers the funds and makes payment upon beneficiary authorization.

There are two options for beneficiaries choosing to directly employ workers: Self-Directed Services/Choice Voucher System and Agency Supported Self-Direction. Through the first option, the beneficiary is the common law employer and delegates performance of the fiscal/employer agent functions to the financial management service, which processes payroll and performs other administrative and support functions through Self-Directed Services, Choice Voucher is for Children on the waiver where a legal guardian would perform the functions of a common law employer on behalf of the child. The beneficiary directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Self-Direction Technical Requirement Implementation Guide. In the Agency Supported Self-Direction model, beneficiaries may contract with an agency which supports self-direction and split the employer duties with the agency. The beneficiary is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the beneficiary. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Self-Direction Technical Requirement Implementation Guide.

A beneficiary may select one or both options. For example, a beneficiary may want to use self-directed services to directly employ a good friend to provide CLS during the week and an agency which supports self-direction to provide CLS on the weekends. The Customer Services Handbook, which includes information about self-directed services, is disseminated to all beneficiaries of mental health services and is provided at the onset of services.

Youth/Families are given information regarding the responsibilities, liabilities and benefits of self-direction as part of the wraparound planning process. A wraparound plan is developed through this family driven, youth guided process with the beneficiary and his/her family, care coordinator, and allies chosen by the family. The family driven, youth guided plan includes services and supports needed by and appropriate for the beneficiary, and identifies the waiver services the beneficiary/family wishes to voucher. An individual budget is developed based on all the services and supports identified in the plan, and must be sufficient to implement that plan. The responsible parent of the SEDW beneficiary can choose to use the Choice Voucher System for the identified self-directed services.

(c) The entities that support beneficiaries who direct their services and the supports that they provide: Through its contract with MDHHS, each PIHP is required to offer information and education to families on participant direction. Each PIHP also offers support to beneficiaries and their families who choose self-direction. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

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

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

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

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

The waiver is designed to afford every participant (or the participant's representative) the opportunity to

elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) The PIHPs are responsible for providing information about participant direction opportunities. General information about self-directed services through the Choice Voucher System is made available to all waiver beneficiaries and their families - initially and on-going - by providing them with a general brochure and with directions how to obtain more detailed information. When a parent of a beneficiary receiving waiver services expresses interest in participating in the Choice Voucher, the care coordinator will assist in gaining an understanding about the Choice Voucher System, and how those options might work for the beneficiary.

Specific options and concerns such as the benefits of participant-direction, the family's responsibilities and potential liabilities are addressed through the person-centered planning process, which is mandated in the Mental Health Code. Each family develops an Individual Plan of Service (IPOS)/wraparound plan through a Family Driven, Youth Guided process. The IPOS developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. The Family Driven, Youth Guided Policy and Practice Guideline require that safety concerns be addressed. The MDHHS Self Determination staff provide support and technical guidance to PIHPs with developing local capacity and with implementing options for participant direction.

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

(c) This information is provided throughout the family's involvement with the PIHP. It starts from the time that the beneficiary and his/her parent approaches the PIHP for services and is provided with information regarding options for participant direction. Beneficiaries living in the community with parents or legal guardians served by the SEDW are to be provided with information about the Choice Voucher System/Self Determination Arrangements. The wraparound planning process is a critical time to address issues related to participant direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that concerns and needs are addressed.

Self-Directed/Choice Voucher enrollment begins when the PIHP and the beneficiary's representative reach an agreement on the IPOS, the services authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each beneficiary's representative who chooses to direct services and supports on behalf of the SEDW beneficiary signs a Choice Voucher Agreement with the PIHP. This agreement is one of three required agreements needed to implement Choice Voucher arrangements, and clearly defines the duties and responsibilities of the parties (i.e., the FMS, the beneficiary/parent as employer or contractor of the waiver provider, and the waiver service provider him/herself).

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Community Living Supports		
Respite		
Home Care Training, Non-Family		
Overnight Health and Safety Support		
Financial Management Services		
Home Care Training, Family		
Therapeutic Activities		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

Yes. Financial Management Services are furnished through a third party entity. (*Complete item E-1-i*).

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

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

FMS providers are procured through an RFP process and evaluated for selection through Financial Management Services Readiness Review as well as meeting the minimum operational requirements required per PIHP contract specified in 2 CFR 200, 45 CFR 92.40 and 42 CFR 438.12.

A contract between the PIHP contracted network provider and the FMS is developed and signed that outlines the roles, responsibilities, basis and process for payment.

The PIHP offers the beneficiary and his/her parent or guardian (i.e., the beneficiary's representative) a choice among available FMS entities that meet the qualifications for this provider type. If the beneficiary's representative identifies a qualified FMS not currently on the provider panel, that FMS may apply to the PIHP to be included on the provider panel. A contract between the PIHP and the FMS is developed and signed that outlines the roles, responsibilities, basis and process for payment.

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

The FMS gets compensated via the PIHP billed monthly as a waiver service for each beneficiary. The contract between the PIHP and the FMS stipulates the conditions of the agreement including the role and responsibility of the FMS and how the FMS is compensated for the financial management services it provides.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

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

1. To receive, safeguard, manage and account for funds provided by the CMHSP on behalf of each beneficiary and maintain complete and current financial records and supporting documentation verifying expenditures paid by the FMS and a chart of accounts.
2. To assist families to understand billing and documentation responsibilities.
3. To perform the financial administrative duties of employer and provide employer agent services to the beneficiary and his/her representative directly employing staff or contracting with clinical service providers. The FMS must abide by all federal and state laws regarding payroll taxes and shall remain current with all payroll tax requirements. Both the PIHP and the family representative must provide copies of all required employment documents including the Medicaid Provider Agreement to the FMS.
4. To disburse funds to vendors and other providers of services and supports as directed by each family for the services and supports selected and in accordance with the family driven youth guided plan, only upon receipt of all required agreements including the Medicaid Provider Agreement and timesheets or invoices approved by the family representative.
5. To maintain complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the FMS on behalf of each beneficiary. These records must be retained for seven years from the start of FMS services.
6. To record and maintain a monthly report of services and expenditures for each beneficiary to keep the PIHP and the family informed of utilization and expenditures for services.
7. To safeguard all confidential information including the results of any background checks, and/or other documents pertaining to providers of services as needed or requested by family and/or the CMHSP.
8. To flag for the PIHP and the family, deviations in provision of services authorized in accordance with the beneficiary's family driven, youth guided plan of service.
9. To reconcile all accrued expenses/accounts payable by the end of the fiscal year.
10. To make records regarding beneficiary available to the PIHP (on behalf of the State Medicaid Agency) as requested and to allow each family access to their own records.
11. To commission a full financial audit of the FMS's books and records as required by the PIHP and/or MDHHS.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

- (a) MDHHS requires that PIHPs develop and implement a plan for assessing and monitoring FMS performance that involves families and their allies in the assessment and monitoring. The plan should include a performance review process at least annually. Elements of the plan for assessing and monitoring FMS performance must minimally include:
1. Fulfillment of FMS Agreement requirements;
 2. Competency in safeguarding, managing and disbursing funds;
 3. Ability to indemnify the PIHP pursuant to FMS agreement requirements;
 4. Evaluation of family feedback and experience with and satisfaction of FMS performance with alternate methods for collecting data from families;
 5. Involvement of families and their allies in the development and implementation of the FMS arrangement; and
 6. Performing an audit of a sample of service utilization and expenditure reports.
- (b) The PIHP is responsible for this monitoring. Compliance with the requirement is included in the MDHHS site review process.
- (c) The FMS performance review must be conducted at least annually.

The PIHPs establish specific review teams to plan, implement, and conduct monitoring for 100% of their region’s contracted FMS providers. Per policy, Quality Assurance Performance Improvement (QAPI) staff schedules the reviews, site visits, coordinates all correspondence related to reviews to providers, along with sending final reports and ensuring all corrective action is reviewed and approved in a timely manner. Each review team member reviewed assigned sections of the review. QAPI combines the review documents and sends the final report draft for team approval. Once approved, the final report was sent to the FMS with requests for Corrective Action Plans, as applicable.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

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

When a parent of a beneficiary expresses interest in self-directing services, the care coordinator (or other person selected by the participant's representative) will assist the family in gaining an understanding about the Choice Voucher System and how those options might work for the beneficiary. This includes providing information regarding the responsibilities, liabilities and benefits of these options prior to the PCP process. The IPOS will include the SEDW mental health services needed by and appropriate for the beneficiary. A budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The family will be informed of qualified FMS providers on contract with the PIHP.

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

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Children's Therapeutic Family Care	
Community Living Supports	
Respite	
Home Care Training, Non-Family	
Overnight Health and Safety Support	
Financial Management Services	
Home Care Training, Family	
Therapeutic Overnight Camp	
Therapeutic Activities	

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The family has the freedom to modify or terminate the arrangements for Choice Voucher at any time. The most effective method for making changes is through the person-centered/family-driven/youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement. The decision of a family to terminate participant direction does not alter the need for services as identified in the plan. Upon termination of participant direction, the PIHP has an obligation for assuring that all identified service needs are met by providers on contract with or employed by the PIHP. The PIHP/CMHSP must have a back up plan ready for such time that an arrangement is terminated and will encourage the beneficiary to notify the CMHSP of intent to terminate with as much forewarning as possible to help ensure proper planning for transition. Once notified of desire for termination of the arrangement The PIHP/CMHSP will ensure that health and welfare of beneficiary and services needs are met through a combination of working with the beneficiary's current staff or back up staff and coordination with the contracted provider who will be taking over service delivery. CMHSP will ensure the day of the handoff services are set up correctly and the transition was successful, typically through in person oversight by the support coordinator at time of transition. The Self-Directed Services Technical Requirements sets forth the procedure for the PIHP to follow. The Self Determination Agreement defines the responsibilities of the parties regarding participation and is in effect until it is changed or ended. Either party can initiate a change or end to the agreement by providing written notice to the other party. The PIHP must respond to any such notice from the responsible parent within seven (7) working days.

Termination of the agreement does not alter the need for services as identified in the IPOS and does not affect the beneficiary's right to access services through the PIHP. Upon termination of participant direction, the PIHP/CMHSP has an obligation for assuring that all identified service needs are met by providers. Safeguards for assuring service continuity beyond planning and preparation are enforced through contract requirements.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A PIHP or CMHSP may involuntarily terminate participant direction when the health and welfare of the beneficiary is in jeopardy or other serious problems are resulting from the beneficiary's failure in directing services and supports or when the family consistently fails to comply with contractual requirements. The procedure for the PIHP to follow is: Prior to terminating an agreement, and unless it is not feasible, the PIHP shall inform the beneficiary of the issues that have led to the decision to consider altering or discontinuing the arrangement in writing, and provide an opportunity for problem resolution. Typically, the wraparound planning process will be used to address the issues, with termination being the option of choice if other mutually agreeable solutions cannot be found. In any instance of discontinuation or alteration of a choice voucher arrangement, the local grievance procedure process may be used to address and resolve the issues. The decision of the PIHP to terminate participant direction does not alter the services and supports identified in the plan of service. In that event, the PIHP has an obligation to take over responsibility for providing those services through its network of qualified providers. The PIHP/CMHSP will ensure that health and welfare of beneficiary and services needs are met through a combination of working with the beneficiary's current staff or back up staff and coordination with the contracted provider who will be taking over service delivery. CMHSP will ensure the day of the handoff services are set up correctly and the transition was successful, typically through in person oversight by the support coordinator at time of transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		19
Year 2		38
Year 3		57
Year 4		76
Year 5		96

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

In the Agency Supported Self-Direction model, families serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (described in this document as ASSD provider) is contracted with the PIHP/CMHSP and serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing workers compensation insurance). In the ASSD model, families may get help with selecting their workers (for example, the ASSD provider may have a pool of workers available for consideration by the family). The ASSD provider may also provide back-up workers when the family's regular worker is not available. Like traditional staffing agencies, the ASSD provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that family's directly employed workers cannot provide. The Agency Supported Self-Direction model is also an important option for families who do not want to directly employ workers or who want to transition into direct employment. An FMS provider agency would only be used in ASSD arrangements if the beneficiary were also using budget authority and acting as an employer agent or when using a purchase of services agreement to hire an ASSD provider who is not in the PIHP impaneled network.

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The FMS provider is responsible for conducting criminal history reviews and abuse screenings for directly employed personal assistance providers. The cost is built into their monthly fee.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Not applicable. Same as c-2-a.

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

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Refer professional staff to FMS for purchase of services contract. Terminate personal services contract with unsatisfactory professional staff.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-

1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

- | |
|---|
| <ol style="list-style-type: none">1. Identify clinical service providers and refer to the FMS.2. Execute and terminate purchase of service agreements with clinical service providers.3. Authorize payment for contracted clinical service providers. |
|---|

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An individual budget is a robust reflection of how the person has chosen to allocate their funds to purchase the supports and services of their choice that they need to meet the goals in their plan. They should be invested in their plan and budget to allow them to achieve their vision of living an inclusive, productive, autonomous life. Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP). Both the beneficiary and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the beneficiary. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the beneficiary is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process.

A simple methodology using reliable cost estimating information is used to develop the budget. This is called the Estimated Cost of Services (ECOS) which is included in every IPOS. Each budget is the sum of the units of service multiplied by the period covered, multiplied by the rate for the service as agreed upon by the participant and authorized through the IPOS. The state does not set a uniform rate for each service. This formula allows each self-directed employer to set a wage for their employees within the limits of their budget. Typically, when an existing person-centered service plan is transitioned to an arrangement which supports self-determination, the overall budget is not more than the costs of delivering the services under the previous traditional service plan.

This ECOS is consistently applied to each plan for every beneficiary and gives the beneficiary a baseline for their budget. Through the person-centered planning process, the beneficiary and their team decides how they will utilize the medically necessary dollars to purchase their unique services and supports. The estimated budget in this planning period is based off of assessed need of each beneficiary and cost is set at the rate that would have been used based on the beneficiary's acuity level for each medically necessary service. The details of this constant approach is publicly available can be found in the Self-Direction Technical Requirement Implementation Guide which is published on the MDHHS website. The ECOS is developed through the rates set by each CMHSP for each provider. The ECOS is the total amount of funds used for the current services and that total of funds that must be available for the person's use for planning and developing their individual budget. (Must be robust enough to have resources to follow FLSA laws, cover employer agent and other admin)

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

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

This process involves costing out the services and supports using the rates for providers chosen by the beneficiary and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Workers Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS. Beneficiaries must use a financial management service if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a participant chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a financial management service be used.

Financial management service is a waiver service and is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the financial management service to provide financial management services (FMS) and sets the rate and costs for the services. Actual costs for the FMS will vary depending on the beneficiary's needs and usage of FMS, as well as the negotiated rate between the PIHP and FMS provider.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The budget, which reflects the services identified in the IPOS and includes but is not limited to the self-directed services, is provided to the family annually. The budget is merely a reflection of the services identified in the plan. The mental health agency (PIHP or designee) must provide the family with information on how to request a Medicaid Fair Hearing when the beneficiary's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of the budget adjustment. Information on how to request a Fair Hearing is attached to every IPOS and a copy of that IPOS is distributed to each beneficiary as mandated.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

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

The Materials provided by the PIHP include written information on the development of the individual budget. During the planning process, a family is to be provided clear information and explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the family during individual budget implementation - found in the Estimated Costs of Services.

If the family is opting to make changes that do not affect the overall limit of the budget and will be essentially moving funds from one line item to another in order to adjust amount, scope, duration of supports outlined in the budget, the beneficiary can work with their FMS entity to make and document those changes. The wraparound facilitator will be notified and expected to make adjustments to the IPOS for clarification on any changes to the expected amount, scope and duration in the budget for purposes of oversight that services were rendered as indicated in the plan.

When a family wants to make an adjustment that fundamentally alters the IPOS (for example, substituting one service for another service that is not similar, forgoing services and supports, or using services and supports not authorized) the IPOS must be appropriately modified before the adjustment may be made and must be done through the Family Driven, Youth Guided process then agreed upon through that process by both the family and the CMHSP.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Beneficiaries must use an FMS provider if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs.

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

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

Through the FMS, the care coordinator (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact they have with the beneficiary, the care coordinator (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR 431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

The PIHPs are required to provide timely and adequate notice of any Adverse Benefit Determination. The content of the notice must meet the following requirement:

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

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

- The PIHP provides this Notice to the beneficiary when denying a requested service that is not already in place. This is effective on the decision date.
- The Adverse Benefit Determination Notice is also used when terminating, suspending, reducing a service that is in place, and is provided to the beneficiary 10 days before the effective date, unless there is an exception.
- As long as a written request is received before the effective date, services remain in place until the Notice of Resolution is sent to the beneficiary. If a determination is being made or action is being taken based upon suspect of fraud, the Adverse Benefit Determination Notice is sent to the beneficiary but may only be sent 5 days before the effective date.

Appeal Resolution Notice:

- The notice of resolution must include the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:

- i. Right to request a state fair hearing, and how to do so;
- ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
- iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

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

In unique circumstances where the PIHP submits SEDW applications to MDHHS for review, if the beneficiary is determined to not meet eligibility requirements for the SEDW, an adequate notice is sent to the beneficiary and legal representative (if applicable) by the MDHHS. This notice follows the process described above.

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

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

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

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

- a) The State has established a grievance and appeals system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 10 PIHPs. The Appeal and Grievance Resolution Processes Technical Requirement of the MDHHS/PIHP Contract is applicable to all the PIHPs, the CMHSPs, and their provider networks. The state agency that operates the dispute mechanism is The Michigan Office of Administrative Hearings and Rules (MOAHR).
- b) Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, (e.g., denial, termination, or reduction of a service), and those challenging anything else, (e.g., beneficiary's dissatisfaction with service, quality of care or services provided or aspects of interpersonal relationships between a service provider and the beneficiary). A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

BENEFICIARY APPEALS: Beneficiary Appeals are initiated by notice of an adverse benefit determination (ABD) (action). Upon receipt of an ABD notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has 60 calendar days from the date of the notice of ABD to request an Appeal. 42 CFR 438.402(c)(2)(ii).
2. The Enrollee may request an Appeal either orally or in writing. Oral inquiries seeking to Appeal an ABD are treated as appeals.
3. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: The enrollee files the request for an appeal timely within 60 calendar days from the date on the ABD Notice; the enrollee files for continuation of benefits timely (on or before the latter of within ten (10) calendar days of the PIHP sending the notice of ABD; or the intended effective date of the proposed ABD; and the period covered by the original authorization request has not expired.

PIHP Responsibilities when the Enrollee Requests Appeals-The PIHP must:

1. Provide any reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capability.
2. Acknowledge receipt of an expedited Appeal within 72 hours of receipt. The PIHP must acknowledge receipt of each standard Appeal within five (5) business days.
3. Maintain a record of appeals for review by the State as part of its quality strategy.
4. Ensure that the individual(s) who make the decisions on appeals are individuals: Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; who when deciding an Appeal that involves either involves clinical issues, or a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; and consider all comments, documents, records, and other information submitted by the enrollee and/or their representative without regard to whether such information was submitted or considered in the initial ABD.
5. Provide the enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. The PIHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals.
6. Provide the enrollee and the enrollee's representative the enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP, in connection with the Appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
7. Provide opportunity to include as parties to the Appeal the enrollee and the enrollee's representative or the legal representative of a deceased enrollee's estate.
8. Provide the enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one. The enrollee can request a State Fair Hearing only after receiving notice that the PIHP is upholding the ABD. In the case of a PIHP that fails to adhere to the notice and timing requirements of 30 days, the enrollee is deemed to have exhausted the PIHP's appeals process. The enrollee may initiate a State fair hearing.

Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days from PIHP receipt of the Appeal.

2. Expedited Appeal Resolution (timing):

- a) Each PIHP must establish and maintain an expedited review process for appeals when the PIHP determines (for a request from the enrollee) or the provider indicates (in making a request on the enrollee's behalf or supporting the enrollee's request) that the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- b) The PIHP may not take punitive action against a provider who requests an expedited resolution or supports the enrollee's Appeal.
- c) If a request for expedited resolution of an appeal is denied, the PIHP must: Transfer the Appeal to the timeframe for standard resolution, make reasonable efforts to give the enrollee prompt oral notice of the denial if the PIHP extends the timeframes not at the request of the enrollee, within two (2) calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision and resolve the Appeal as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days.
- d) If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72 hours after the PIHP receives the request for expedited resolution of the Appeal.

Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to 14 calendar days if the enrollee requests or if the PIHP shows (to the satisfaction of the State, upon its request) that there is a need for additional information, and how the delay is in the enrollee's interest.

Appeal Resolution Notice: The PIHP must provide Enrollees with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's right to request a State Fair Hearing, and how to do so and the right to request to receive benefits while the State Fair Hearing is pending, and how to make the request; and the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's ABD.

BENEFICIARY GRIEVANCES: Medicaid beneficiaries have the right to a local grievance process for issues that are not "actions". Generally, the enrollee must file a Grievance with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances. A Grievance may be filed at any time by the enrollee, guardian, or parent of a minor child, or the enrollee's authorized representative.

For each grievance filed by a beneficiary, the PIHP is required to:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability.
2. Acknowledge receipt of the Grievance within 5 business days.
3. Maintain a record of grievances for review by the State as part of its quality strategy.
4. Ensure that the individual(s) who make the decisions on the Grievance are individuals: Who were neither involved in any previous level review or decision-making, nor a subordinate of any such individual, who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues and who consider all comments, documents, records, and other information submitted by the enrollee and/or the enrollee's representative without regard to whether such information was submitted or considered previously.

Timing of Grievance Resolution: Provide the enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP received the Grievance.

Extension of Timeframes: The PIHP may extend the Grievance resolution and notice timeframe by up to 14 calendar days if the enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the enrollee's interest. If the PIHP extends resolution/notice timeframes not at the request of the enrollee, it must make reasonable efforts to give the enrollee prompt oral notice of the delay and within 2 calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision.

STATE FAIR HEARING PROCESS:

A. Federal regulations provide the enrollee the right to an impartial review by a State-level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, after receiving notice that the PIHP is upholding an ABD

after Appeal and when the PIHP fails to adhere to the notice and timing requirements for resolution of appeals as described in 42 CFR 438.408(f)(1)(i).

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions of the review are met: Must be at the enrollee’s option and must not be required before or used as a deterrent to proceed to the State Fair Hearing; must be independent of both the State and the PIHP, must be offered without any cost to the enrollee, must not extend any of the required timeframes and must not disrupt the continuation of benefits.

C. The PIHP may not limit or interfere with the enrollee's freedom to make a request for a State Fair Hearing.

D. The enrollee is given no more than 120 calendar days from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing.

E. The PIHP is required to continue benefits if the conditions described in Section VII - Medicaid Services Continuation or Reinstatement are satisfied and for the duration described therein.

F. If the enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the ABD.

G. The parties to the State Fair Hearing include the enrollee and the enrollee’s representative, or the representative of a deceased enrollee's estate, and the PIHP. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that

the state uses to elicit information on the health and welfare of individuals served through the program.

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

The MDHHS requires reporting on the following critical incidents, immediate reportable events, sentinel event analysis and allegations of abuse, exploitation, and neglect. All critical incident and immediate reportable events are reported through the Customer Relationship Management (CRM) system. Allegations of abuse, exploitation, and neglect are reported to the local Community Mental Health Services Program (CMHSP) Office of Recipient Rights (ORR).

CRITICAL INCIDENT REPORTING AND IMMEDIATE REPORTABLE EVENTS:

MDHHS oversees all critical incidents and immediate reportable events through the CRM to monitor this reporting as incidents/events are submitted for trends, outliers and issues. Review includes requesting and reviewing of required remediations which provide individual (if applicable) and/or systemic responses to prevent reoccurrence. The system allows for MDHHS to ensure the PIHP's process for reporting these incidents and events is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would require submission of a corrective action plan by the PIHP. The corrective action plan effectiveness submitted by the PIHP will be reviewed by MDHHS during ongoing reviews of critical incident reports and event reporting when submitted.

MDHHS requires the PIHPs and CMHSPs to report critical incident data and related information into the CRM as a measure of how well the PIHP/CMHSP and its contracted providers monitor the care of vulnerable service recipients, including SEDW beneficiary. The Critical Incident Reporting System (CIRS) through the CRM enables MDHHS to receive data on beneficiaries within specified timeframes, depending on the type of event. People enrolled under the SEDW are a reportable population in the CIRS. CIRS requires the PIHP to report the following events to MDHHS: suicide, non-suicide death, emergency medical treatment due to injury, falls or medication error, hospitalization due to injury, falls or medication error, and arrest of beneficiary. Timeframes for reporting the five specified events in the CIRS are:

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

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

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

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

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

Definitions for Critical Incident Reporting System (CIRS):

- **Suicide:** A Beneficiary's death shall be reported as a suicide when either one of the following two conditions exists:
 1. The CMHSP serving the beneficiary determines, through its death review process, that the beneficiary's death was a suicide, or
 2. The official death report (i.e., coroner's report) indicates that the beneficiary's death was a suicide
- **Non-suicide Death:** Any death, for beneficiary in the reportable population, that was not otherwise reported as a suicide. The reportable population includes any SEDW beneficiary.
- **Emergency Medical Treatment due to Injury, Fall or Medication Error:** Situations where an injury to a beneficiary, injury due to a beneficiary fall 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, fall or medication error.
- **Hospitalization due to injury, fall or medication error:** Situations where an injury to a beneficiary, injury due to a beneficiary fall or a medication error results in hospitalization of the beneficiary. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.
- **Fall:** Defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.
- **Medication error:** Defined as a situation where a mistake is made when a beneficiary takes prescribed medication (i.e.,

incorrect dosage taken, prescription medication taken that is not prescribed, medication taken at wrong time, medication used improperly), or a situation where non-prescription medication is taken improperly.

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

The MDHHS/PIHP contract requires the PIHP to report immediate reportable events into the CRM when any of the following egregious events occur:

- Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation (report within 48 hours of death or PIHP's notification of death),
- relocation of a beneficiary's placement due to licensing suspension or revocation (report to MDHHS within five business days),
- conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of his or her job duties or responsibilities (report to MDHHS within five business days)
- an occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours (report to MDHHS and
- Critical Incidents which may be newsworthy or represent a community crisis must be reported immediately.

SENTINEL EVENT

A Sentinel Event is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The PIHP or delegated provider must prepare and file critical incident reports that include the following components:

- i. Provider determination whether critical incidents are sentinel events.
- ii. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.
- iii. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.

OFFICE OF RECIPIENT RIGHTS

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

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

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

OTHERS: Other agencies, such as law enforcement, protective services, or licensing, may receive reports of allegations of abuse, neglect, and exploitation. Where beneficiaries live in licensed settings, Michigan law and rules (for example, R 400.14311 for small and large licensed AFC homes) require licensee to complete an Incident/Accident Report; a copy of which is forwarded to the CMHSP ORR, CMHSP and responsible agency) which would assure the immediate health and welfare of the beneficiary, as well as that of any other mental health recipients in the home.

The report includes the following:

1. A licensee shall make a reasonable attempt to contact the resident’s designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident’s designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:
 - a) The death of a beneficiary.
 - b) Any accident or illness that requires hospitalization.
 - c) Incidents that involve any of the following:
 - i. Displays of serious hostility
 - ii. Hospitalization.
 - iii. Attempts at self-inflicted harm or harm to others.
 - iv. Instances of destruction to property.
 - d) Incidents that involve the arrest or conviction of a beneficiary as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
2. An immediate investigation of the cause of an accident or incident that involves a beneficiary, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
3. If a resident is absent without notice, the licensee or direct care staff shall do both of the following:
 - a) Make a reasonable attempt to contact the resident’s designated representative and responsible agency.
 - b) Contact the local police authority.
4. A licensee shall make a reasonable attempt to locate the resident through means other than those specified in subrule (3) of this rule.
5. A licensee shall submit a written report to the resident’s designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
6. An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. “Incident” means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
 - a) The name of the person who was involved in the accident or incident.
 - b) The date, hour, place, and cause of the accident or incident.
 - c) The effect of the accident or incident on the person who was involved and the care given.
 - d) The name of the individuals who were notified and the time of notification.
 - e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.
 - f) The corrective measures that were taken to prevent the accident or incident from happening again.
7. A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

DEFINITIONS:

Definitions of Abuse and Neglect (MDHHS Administrative Rule 330.7001):

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

Abuse class I means a nonaccidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient. "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Sexual abuse means any of the following:

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

Sexual contact means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in asexual 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.

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

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDHHS entitled "YOUR RIGHTS When Receiving Mental Health Services in Michigan" at the time of admission into services and periodically thereafter. The SEDW beneficiary's care coordinator will provide information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of SEDW services and as often as needed by the beneficiary or the informal caregivers, but at least annually during a person-centered planning meeting. This is in accordance with Section 330.1706 of the Code: "... applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients. From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the Code mandated protections from abuse, neglect, and exploitation, and the how beneficiaries (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the beneficiaries may have experienced abuse, neglect or exploitation.

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

The MDHHS/PIHP contract requires that each PIHP must have a Customer Services Unit that provides information about mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a beneficiary. The Customer Services Unit may also, upon request of the beneficiary, 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 beneficiaries, family members, advocates and interested others. Additionally, the MDHHS holds annual Recipient Rights, Beneficiary, and Home and Community Based Waiver Conferences, all of which include beneficiaries and/or their families. These conferences provided Recipient Rights training that describe beneficiary rights and the complaint resolution and appeal process.

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

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

EVENT REPORTING: The MDHHS/PIHP Contract, following event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service. The written report will include beneficiary information, date, time and place of death (if in a foster care setting, the foster care license #), final determination of cause of death (from coroner's report or autopsy), summary of conditions (physical, emotional) and treatment or interventions preceding death, any quality improvement actions taken as a result of an unexpected or preventable death, and the PIHP's plan for monitoring to assure any quality improvement actions are implemented.

SENTINEL EVENT: The PIHP, or its CMHSP affiliate with delegated responsibility, must review the incident to determine if it meets the criteria and definitions for sentinel events and are related to practice of care. Depending on the type of incident, it may also be required to report on the CIRS to MDHHS. The MDHHS/PIHP contract, requires that each PIHP's Quality Assessment Performance Improvement Plan (QAPIP) addresses sentinel events. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

All unexpected deaths (deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect) of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

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

CRITICAL INCIDENT REPORTING SYSTEM in the CRM: The CIRS in the CRM requires the PIHPs and CMHSPs to report the following events to MDHHS: suicide, non-suicide death, emergency medical treatment due to injury, fall or medication error, hospitalization due to injury, fall or medication error, and arrest of beneficiary. PIHPs/CMHSPs will submit reports directly (through Application Programming Interface) into the CRM. Incidents reported in the CRM would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. Additionally, some of the incidents reported in the CRM such as a death or injury, could result in a criminal investigation or referral to Child or Adult Protective Services. MDHHS staff review incidents that are considered priorities as they are reported, 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). This allows MDHHS to request

more immediate corrective action and response to these priority incidents. PIHPs have 30 days to respond to remediations generated by priority incidents reported or those requested by MDHHS staff. The CRM allows for MDHHS to monitor for trends, outliers, and issues more closely and in real time. In addition, the CRM allows for CMHSPs/PIHPs to indicate whether CPS, APS LARA AFC Licensing or ORR investigations have been opened to investigate the incident. CMHSPs/PIHPs are also able to identify those incidents reported which have been determined a Sentinel Event. Section G-1-b of this application defines incidents and identifies timelines for reporting to the state.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP affiliates of the PIHPs shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the office shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the beneficiary within five days acknowledging receipt of the complaint and then provides written updates every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report of the investigation including the conclusion of the office of recipient rights and the action or plan of action to remedy a violation to the complainant, recipient if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights. Information gathered from investigations is reviewed for trends and becomes a focus of the on-site visitation conducted by MDHHS to CMHSPs. Aggregate data are shared with MDHHS, the Quality Improvement Council (QIC) and Federal Compliance staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

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

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

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

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

CRITICAL INCIDENT REPORTING SYSTEM in the CRM: PIHPs/CMHSPs will submit reports directly (through Application Programming Interface) into the CRM. Incidents reported in the CRM would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. MDHHS staff review incidents that are considered priorities as they are reported, 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). The system allows for MDHHS to ensure the PIHP's process for reporting these incidents and events is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would require submission of a corrective action plan by the PIHP. PIHPs have 30 days to respond to remediations generated by priority incidents reported or those requested by MDHHS staff. The CRM allows for MDHHS to monitor for trends, outliers, and issues more closely and in real time. MDHHS will monitor incidents for SEDW beneficiaries, establish a baseline "penetration" rate and set targets for reductions in the rate of critical incidents that will result from systems improvement strategies from systems improvement strategies identified in Appendix H and oversight of critical incidents.

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

ON A QUARTERLY BASIS, THE PIHPS TRACK AND ANALYZE THE USE OF ALL PHYSICAL MANAGEMENT AND INVOLVEMENT OF LAW ENFORCEMENT FOR EMERGENCIES, AND THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES BY EACH BENEFICIARY RECEIVING THE INTERVENTION, THIS INCLUDES UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS. THE DATA ON THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES MUST BE EVALUATED BY THE PIHP'S QAPIP OR THE CMHSP'S QIP, AND BE AVAILABLE FOR MDHHS REVIEW.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

The Michigan Mental Health Code 330.1726 requires (in part):

- A recipient is entitled to unimpeded, private and uncensored communication with others by mail and telephone and to visit with persons of his or her choice;
- The right of a recipient to communicate by mail or telephone or receive visitors shall not be further limited except as authorized in the person's individual plan of services. The Michigan Mental Health Code 330.1744 requires (in part):
 - The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.
 - Any restrictive or intrusive intervention must be identified through the Person-Centered Planning process and must be detailed in the individual's IPOS consistent with the HCBS Final Rule and the HCBS Medicaid Provider Manual chapter. This requirement is not impacted by the development of a Behavior Treatment Plan
 - Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan;
 - Identify the specific assessed need(s);
 - Document the positive interventions and supports used previously;
 - Document less intrusive methods that were tried and did not work, including how and why they did not work;
 - Include a clear description of the condition that is directly proportionate to the assessed need;
 - Include regular collection and review of data to measure the effectiveness of the modification;
 - Include established time limits for periodic review of the modification;
 - Include informed consent of the individual; and
 - Include assurances that the modifications will cause no harm to the individual.

All restrictive or intrusive interventions must be reviewed on a quarterly basis and recorded in a progress note. If the review determines that changes are required, this will be reflected in an amendment to the IPOS.

MDHHS Administrative Rules 330.7199 requires (in part):

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

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

The MDHHS contract with the PIHPs and CMHSPs includes MDHHS Standards for Behavior Treatment Plan Review Committees, which addresses the use of restraint, seclusion, intrusive and restrictive interventions.

It is the policy of MDHHS that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here in section IV, with beneficiaries served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the beneficiary or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards contained MDHHS/PIHP contract, including those for its appointment, duties, and functions. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. The Committee shall be comprised of at least three individuals, one of whom shall be a board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist as defined in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the

beneficiary whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms. The Committee shall meet as often as needed. Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision-making.

The function of the committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
 - Aversive Techniques: Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.
 - Physical management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the beneficiary or others at imminent risk of serious physical harm. To ensure the safety of each beneficiary and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.
 - Restraint: The use of physical devise to restrict a's beneficiary's movement. Restraint does not include the use of a device primarily intended to provide anatomical support
 - Seclusion: The temporary placement of a recipient in a room, alone, where egress is prevented by any means

2. Expediently review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.
 - Peer-reviewed literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.
 - Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the beneficiary for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the beneficiary or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control a beneficiary's behavior or restrict the beneficiary's freedom of movement and is not a standard treatment or dosage for the beneficiary's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
 - Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the beneficiary's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the beneficiary; prohibiting unlimited access to food when that access would be harmful to the beneficiary (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of a beneficiary. Use of restrictive techniques requires the review and approval of the Committee.

3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral

supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

•Positive behavioral supports: A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the beneficiary or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the beneficiary's condition, or when the beneficiary requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.

5. Assure that inquiry has been made about any known medical, psychological or other factors that the beneficiary 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 community partners, including beneficiaries who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the beneficiaries served.

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

On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each beneficiary receiving the intervention, as well as:

- 1.Dates and numbers of interventions used.
- 2.The settings (e.g., beneficiary's home or work) where behaviors and interventions occurred
- 3.Observations about any events, settings, or factors that may have triggered the behavior.
- 4.Behaviors that initiated the techniques.
- 5.Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
- 6.Description of positive behavioral supports used.
- 7.Behaviors that resulted in termination of the interventions.
- 8.Length of time of each intervention.
- 9.Staff development and training and supervisory guidance to reduce the use of these interventions.
- 10.Review and modification or development, if needed, of the beneficiary's behavior plan.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDHHS review. Physical management permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

The use of physical management would also generate an incident report that is reviewed by the CMHSP

ORR. If after investigation by the CMHSP ORR, it is determined that staff used physical management (1) when there is not an imminent risk of harm to the recipient or others, (2) if the physical management used is not in compliance with the techniques approved by the CMHSP, (3) the physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service, and/or (4) physical management is used when other lesser restrictive measures were possible but not attempted immediately before the use of physical management, the CMHSP ORR will substantiate Abuse Class II Use of Unreasonable Force, against the staff. The Michigan Mental Health Code mandates that disciplinary action for any substantiated abuse or neglect.

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

MDHHS monitors the critical incident reporting through the CIRS. Any death or injury requiring emergency treatment or hospitalization that resulted from the use of physical management would be reported within the timeframes specified in G-1-d.

In addition to monitoring critical incident reporting, MDHHS oversees the activities of the CMHSP Behavior Treatment Plan Review Committees through annual site reviews and more frequent oversight if issues or critical incidents related to the use of restrictive interventions are noted. If critical incidents are reported related to the use of physical management, MDHHS may require the PIHP and CMHSP staff to receive training in positive behavioral supports, as well as recommend other approaches or strategies as appropriate. The data on the use of intrusive and restrictive techniques from CMHSP Behavior Treatment Plan Review Committees must be available for MDHHS review.

The site review team verifies that the process for the Behavior Treatment Plan Review Committees is being implemented per MDHHS policy. If the process is not being implemented per MDHHS policy, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP/CMHSP.

The MDHHS site review team ensures that any restrictive or intrusive measures in place are supported by an HCBS compliant IPOS.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDHHS review.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of seclusion

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

MDHHS requires that any beneficiary receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict a beneficiary's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, the Medicaid Specialty Supports and Services Program contract between MDHHS and the PIHPs; the Agreement Between MDHHS and CMHSPs For Managed Mental Health Supports and Services.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigation of reports of unlawful restraint and/or seclusion in an adult licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Children's licensed foster homes and CCIs are regulated by the Division of Child Welfare Licensing, and inspections are completed annually.

Mechanical or chemical restraint and seclusion are prohibited in adult licensed foster care homes per DHS Administrative Rule 400.14308 as follows:

R 400.14308 Resident behavior interventions prohibitions.

- (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
- (a) Use any form of punishment.
 - (b) Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
 - (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
 - (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS site review team, which reviews agency policy for consistency with State law during annual 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 beneficiaries or staff.

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

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

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of

seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

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

b. Medication Management and Follow-Up

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

Most Waiver for Children with Serious Emotional Disturbance (SEDW) beneficiaries live with family and medication management and administration are the family's responsibility. In those few instances where the beneficiary and/or family use licensed settings, the PIHPs and their affiliated CMHSPs have ongoing responsibility for "second line" management and monitoring of beneficiary medication regimens ["first line" management and monitoring is the responsibility of the prescribing medical professional]. The beneficiary's individual plan of services and supports must contain complete information about their medications regimen [i.e., what each medication is for; frequency and dosage; signs and symptoms suggesting/requiring attention, etc.]. These details and any other monitoring recommendations from the prescribing professional are shared with the members of the beneficiary's planning team [as authorized by the beneficiary], and all provider staff with medication administration/self-administration assistance/monitoring responsibilities. This helps all within the beneficiary's planning/service/support network to know when to request a formal medication review outside those scheduled within the plan. Care coordinators' monitoring of beneficiaries includes general monitoring of the effectiveness of the beneficiary's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with beneficiaries, and discussion with direct care and other staff as appropriate.

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

Michigan's Department of Licensing and Regulatory Affairs licenses and certifies adult foster care settings that provide specialized residential services.

Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. LARA licensing inspections occur every two years, as well as conducting special investigations when needed. Children's licensed foster homes and CCIs are regulated by the Division of Child Welfare Licensing, and inspections are completed annually.

Any use of behavior modifying medications requires specific approval of a Behavior Treatment Plan Review Committee. These requirements are outlined in contracts with the PIHPs and specify committee membership and review requirements are included in G-2-b. Committee reviews of the use of behavior modifying medications must be completed at least quarterly, but may be completed more frequently at the discretion of the committee. Reports from the Committee must be submitted to MDHHS for SEDW beneficiaries on a quarterly basis.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the PIHP must follow-up to address the beneficiary's health and welfare as applicable, report through the critical incident reporting system (CIRS) and conduct a sentinel event investigation.

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

In addition to the regular Medication Reviews by the PIHP/CMHSP medical professionals specified in the plan, care coordinators and others are trained to spot signs and symptoms of potentially harmful practices and can request an unscheduled Medication Review and a planning meeting to address any confirmed issues.

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

During annual MDHHS site reviews of the PIHPs, MDHHS staff on the site review team evaluate residential service provider compliance with staff training and incident reporting requirements, as well as the PIHP's monitoring and follow-up of medication errors. In addition, the site reviews evaluate compliance with Behavior Treatment Plan Committee. If a potentially harmful practice is identified at any level, the PIHP works with the provider to correct the practice. If a residential provider does not cooperate toward correction, the PIHP may file a complaint with MDHHS, and per rule R330.1804: (2) Upon receipt of a complaint regarding the provision of specialized program services, the department shall conduct a review within 30 days to determine whether these rules have been violated. The department shall issue a written report of its findings and provide a copy to the department of human services, the complainant, the facility, and the placing agency; (3) The department shall issue a complaint against a facility if rule violations warrant; (4) Failure of the licensee to fully cooperate with the department in connection with inspections and investigations is a ground for the denial, suspension, or revocation of, or refusing to renew, a facility's certification. Non-cooperation from non-residential providers can result in the PIHP revoking their contracts/removing them from their waiver services provider panel.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

Not applicable. *(do not complete the remaining items)*

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

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

The Michigan Administrative Rule 330.7158 addresses medication administration:

- (1) A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
- (2) A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
- (3) A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
- (4) A provider shall review the administration of a psychotropic medication periodically as set forth in the recipients individual plan of service and based upon the recipients clinical status.
- (5) If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
- (6) A provider shall record the administration of all medication in the recipient's clinical record.
- (7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.

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

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

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

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

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

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

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

Providers responsible for medication administration are required to record medication errors as noted in G-3-c.i above in Administrative Rule 330.7158 (7). PIHPs must report certain medication errors to MDHHS per the MDHHS/PIHP and CMHSP contracts.

"Medication errors" mean: wrong medication; wrong dosage; double dosage; or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which participants have refused medication. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDHHS-MHSA when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur.

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

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

During these site reviews, MDHHS staff verifies the PIHP's process for Critical Incident Reporting is being implemented per MDHHS policy.

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 instances of 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 within timeframe as required by MDHHS/PIHP contract. Numerator: Number of critical incidents reported for SEDW participants within timeframe as required by MDHHS/PIHP contract. Denominator: all critical incidents reported for SEDW participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Incident Reports

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of enrollees requiring hospitalization due to injury related to the use of physical management (PM) where remediation was completed. Numerator: Number of enrollees requiring hospitalization due to injury related to the use of PM where remediation was completed. **Denominator:** Number of enrollees requiring hospitalization due to injury related to the use of PM.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1061 1264 1144" type="text"/>
Other Specify: <input data-bbox="408 1285 647 1368" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1285 1264 1368" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1509 1264 1592" type="text"/>
	Other Specify: <input data-bbox="718 1733 954 1816" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

NUMBER AND PERCENT OF CRITICAL INCIDENTS REPORTED FOR SEDW ENROLLEES THAT WERE FOUND TO BE SUBSTANTIATED. NUMERATOR: NUMBER OF CRITICAL INCIDENTS REPORTED FOR SEDW ENROLLEES. DENOMINATOR: ALL SEDW ENROLLEES.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: <input style="width: 100%; height: 20px;" type="text"/>		Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

NUMBER AND PERCENT OF BENEFICIARIES REQUIRING HOSPITALIZATION DUE TO MEDICATION ERROR WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS TYPE. NUMERATOR: NUMBER OF BENEFICIARIES NOT REQUIRING HOSPITALIZATION DUE TO MEDICATION ERROR. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF HOSPITALIZATION FOR MEDICATION ERRORS

Data Source (Select one):
Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of substantiated abuse and neglect events reported for waiver participants that are remediated. Numerator: Number of substantiated abuse and neglect events reported for waiver participants that are remediated. Denominator: All substantiated abuse and neglect events reported for waiver participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MDHHS Office of Recipient Rights

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

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text" value="Semi-annually"/>

Performance Measure:

Number and percent of participants who have received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of participants who received information and education in the prior year. Denominator: Number of participants sampled.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

NUMBER AND PERCENT OF BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT DUE TO MEDICATION ERROR WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS TYPE. NUMERATOR: NUMBER OF BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT NOT DUE TO MEDICATION ERROR. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF EMERGENCY MEDICAL TREATMENT FOR MEDICATION ERRORS.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Number of records being reviewed where the BTPRC policy was followed.

Numerator: Number of records being reviewed where the BTPRC policy was followed. **Denominator:** number of records reviewed with Behavioral Treatment Plans.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of completed Individual Plans of Service (IPOS) with restrictions identified and are in compliance with HCBS requirements. Numerator: Completed IPOS with restrictions identified that are in compliance with HCBS requirements. Denominator: All completed IPOS with restrictions identified.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="Proportionate random sample, 95% confidence interval"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

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

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

Performance Measures

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

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

Performance Measure:

Number of records being reviewed where the waiver participants received health care appraisal ACCORDING TO THE PARAMETERS SET IN THE APPROVED WAIVER. Numerator: Number of records being reviewed where the waiver participants received health care appraisal. Denominator: Number of records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

MDHHS will analyze a 100% sample of all reported critical incidents involving SEDW beneficiaries 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. MDHHS and the Quality Improvement Council are particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effectiveness of preventive strategies. MDHHS also has regular meetings with MDHHS 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 beneficiary has an IPOS developed based on the beneficiary'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 beneficiary. Required staff training includes training in the IPOS, as well as in Recipient Rights. The IPOS is overseen by the Child and Family and care coordinator.

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 participant has a short-term response to assure the immediate health and welfare of the participant for whom the incident was reported and a longer-term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the beneficiary's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <input data-bbox="317 313 743 394" type="text"/>	
	Continuously and Ongoing
	Other Specify: <input data-bbox="813 624 1240 705" type="text"/>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

spells out:

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

The MDHHS incorporates all of the programs operated in the public mental health system, including the Michigan 1115 Behavioral Health Demonstration, Habilitation Support Waiver (HSW), Children's Waiver Program (CWP), and the Waiver for Children with Serious Emotional Disturbance (SEDW). The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of fund source. The MDHHS Site Review team will conduct comprehensive annual reviews at each PIHP (and affiliate CMHSPs). The site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of §1915(c) waiver beneficiaries are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, beneficiary consumer/community partner stakeholder meetings and beneficiary consumer interviews. In addition to identifying individual issues that are addressed in remediation, the MDHHS findings are also used for identifying trends to implement systems improvements. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiary.

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 Behavioral Health Code Charts and Provider Qualifications; review of PIHP policy for the Critical Incident Reporting System and verification that the process is being implemented per MDHHS policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDHHS policy; 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 annual site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random sample at the 95% confidence level for the annual review for each PIHP/CMHSP. At the 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 adhering to the CFA&P requirements, INCLUDING ALIGNMENT WITH MDHHS APPROVED CFA&P SCENARIOS AND ANY ASSOCIATED CFA&P IMPLEMENTATION PLANS
- is updated at least annually Clinical record reviews are also completed to determine that beneficiaries are afforded choice between waiver services and institutional care and between/among service providers and that services are provided as identified in the IPOS. MDHHS contracted staff conducts beneficiary interviews with a random sample of those beneficiaries whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with beneficiaries who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the waivers. The findings of each PIHP/CMHSP site review are sent to the PIHP/CMHSP with the requirement that the PIHP/CMHSP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations will be reviewed at next annual PIHP/CMHSP site review to ensure all concerns have been appropriately addressed. Results of the MDHHS site reviews are shared with MDHHS management team, the Quality Improvement Council (QIC), and AHCBS staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements. Michigan's QAPIP has been developed with the input of beneficiaries and the Mental Health QIC. Michigan's QAPIP is revised with the Michigan 1115 Behavioral Health Demonstration and reflects the activities, concerns, input or recommendations from the MDHHS's

Encounter Data Integrity Team (EDIT), EQR activities and the terms and conditions from CMS' previous waiver approvals.

The MDHHS Site Review Protocol is reviewed and revised to address changes in policy resulting from trends or system improvements. The existing infrastructure in Michigan includes Michigan 1115 Behavioral Health Demonstration to allow Michigan to provide mental health services not otherwise covered under the State Plan through a managed care delivery system. The concurrent §1115/1915(c) waivers enables Michigan to use Medicaid managed care program features such as quality improvement performance plans and external quality reviews as important parts of effective monitoring of the HSW. Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the Quality Assessment and Performance Improvement Programs. These elements were required as part of the AFP (2002) and are now part of the MDHHS/PIHP contracts and they are reviewed by MDHHS staff and/or the EQR process. While a review of the following three areas is not specific to the HSW, it assures overall quality services for all beneficiaries. EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. MDHHS contracts with Health Services Advisory Group (HSAG) to conduct the EQR. The EQR consists of desk audits of PIHP documents, on-site visits to PIHPs or both. One EQR component addresses PIHP compliance to BBA requirements. The other two EQR activities involve validation of PIHP performance improvement projects and performance indicators. The EQR address requirements for customer services: staff who are knowledgeable about referral systems to assist beneficiaries in accessing services, a range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSPs network, performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP, focus of customer services is customer satisfaction and problem avoidance, assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications, and the relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations. Appeals and Grievances Mechanisms: The EQR reviews the process, information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record-keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDHHS. MDHHS uses its Appeals and Grievances database to track the trends of the types of requests for fair hearing and their resolution, to identify PIHPs that have particularly high volumes of appeals, to identify themes, such as appeals related to a specific service and to address any trends that are noted through training, policy clarification, or other methods. MDHHS also has regular meetings with the Administrative Tribunal to address trends and identify solutions. Quality Assessment and Performance Improvement Programs: The MDHHS contracts with PIHPs require that Quality Assessment and Performance Improvement Programs (QAPI) be developed and implemented. The EQR monitors the PIHP implementation of their local QAPI plans that must include the required standards. MDHHS site reviews include review of implementation of standards for sentinel events and credentialing of providers. MDHHS collects data for performance indicators and performance improvement projects as described in b.i. below.

In addition to the AHCBS strategies implemented for all beneficiaries, the SEDW staff review all applications and monitor the timeliness of re-certifications by way of the web-based SEDW database. The SEDW staff may participate in MDHHS site reviews of clinical and administrative records or provide technical consultation as requested by the Site Review Team during a PIHP/CMHSP review.

Data from site reviews and consultations has been used for systems improvement activities. Examples include: providing technical assistance to PIHPs and CMHSPs; mandating technical assistance for sites with high levels of out-of-compliance; completing additional follow up record reviews to ensure Quality Improvement Project is being implemented; and identifying topics for technical assistance webinars or conferences at both state and local levels to address systemic issues.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div data-bbox="320 624 868 696" style="border: 1px solid black; height: 30px; width: 100%;"></div>	Other Specify: <div data-bbox="943 624 1490 714" style="border: 1px solid black; padding: 5px;"> The QIC meets every other month. For the PIHPs/CMHSPs and MDHHS, QI activities are ongoing. </div>

b. System Design Changes

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

MDHHS uses performance indicators to measure the performance of the PIHP on a number of domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management. Data collected for performance indicators can be identified at the individual SEDW beneficiary level if necessary.

Indicators are used to alert MDHHS of systemic issues and PIHP-specific issues that need to be addressed immediately; to identify trends to watch; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter data located in MDHHS's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDHHS and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action.

Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDHHS web site. Results of the performance indicators are shared with MDHHS management team, the QIC and SEDW staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

PIHPs are required by contract to submit Medicaid Utilization and Net Cost (MUNC) reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP and can be analyzed at the SEDW beneficiary level. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDHHS to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDHHS management team, the EDIT, and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Critical Incidents are reported, reviewed, investigated and acted upon at the local level by each PIHP for all SEDW beneficiaries.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDHHS semi-annually. Aggregate data are shared with MDHHS management team and the QIC. Information is used by MDHHS to take contract action as needed, becomes the focus of on-site reviews conducted by MDHHS, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP Offices of Recipient Rights (ORR) report summaries of all allegations received and investigated, identify intervention taken, and the number of allegations substantiated. The summaries are reported by category of rights violations. An annual report is produced by the State ORR and submitted to community partners and the Legislature. Data collection improvements distinguish Medicaid beneficiaries from other beneficiaries that are served.

The MDHHS staff collaborates with the Quality Improvement Council to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and community partner concerns. Michigan requires all PIHP/CMHSPs to conduct a minimum of two performance improvement projects. All PIHPs/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDHHS; in the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide. All PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHP/CMHSPs choose their second performance improvement project.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDHHS performance improvement project reports are shared with MDHHS management team, the QIC and SEDW staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDHHS staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDHHS site reviews and the EQRs are shared with MDHHS management team and the QIC.

Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Consolidated Reporting:

The MDHHS system improvement strategy encompasses 1915(i) SPA with the following three 1915(c)'s waivers: Children's Waiver program, Habilitation Supports Waiver, and Children with Serious Emotional Disturbances Waiver. MDHHS designed the consolidated quality improvement strategy to assess and improve the quality of services and supports provided through the available the 1915(c) services waiver options and the 1915(i) state plan. This is evident in the following components;

- A) beneficiary services-all 1915(c) waivers and the 1915(i) offer similar services to beneficiaries to remain in the community with the focus on the provision of services and supports to maintain or increase a level of functioning in order to achieve a beneficiary's goals of community inclusion and participation, independence, recovery, or productivity.
- B) beneficiary safeguards-all 1915(c) waivers and the 1915(i) follow the same beneficiary safeguards outlined throughout the individual waiver and 1915(i) SPA applications.
- C) quality management: the information below outlines the approach which is the same or similar across 1915(c) waivers and the 1915(i).

The quality management approach is the same or similar across waivers and the 1915(i):

- a) methodology for discovering information: the state draws from several tools to gather data and measure individual and system performance. Tools utilized include the record review protocol, the CHAMPS, web-based database called the Waiver Support Application, and a critical incident reporting system across all waivers and 1915(i) beneficiaries.
- b) manner in which individual issues are remedied: MDHHS is the single state agency responsible for establishing the components of the quality improvement strategy which includes the remediation of all waiver and 1915(i) issues at an individual level and all actions and timelines are recorded and tracked through annual monitoring activities.
- c) process for identifying and analyzing trends/patterns: data gathered from the record reviews will be used initially to foster improvements and provide technical assistance at the agency whose records are being reviewed. Annually, this data will be compiled to look for systemic trends and areas in need of improvement and published in the state's annual report. Using encounter data, measure penetration rates of beneficiaries who access services at the PIHP level to determine a baseline, median, and negative statistical outliers. The state will track and trend critical incidents that involve beneficiaries at the PIHP level: baseline, then identify negative statistical outliers and track and trend requests for Medicaid fair hearing by beneficiaries, and track and trend by PIHP the fair hearing decisions that are found in favor of the beneficiary.
- d) majority of the performance indicators are the same: the majority of the performance measures associated with CMS assurances are the same.

The provider network is the same across the 1915(c) waiver programs and the 1915(i). All provider types (i.e. licensed/non-licensed, certified/non-certified) within the 1915(c) waiver programs and the 1915(i) are required to meet the same training and background check requirements according to policy in order to furnish HCBS.

Provider oversight is the same across the 1915(c) waiver programs and the 1915(i) and all services are included in the consolidated reporting.

Sampling Methodology for Consolidated Reporting:

Pulling a statistically significant sample from the total population of all 1915(c) waivers (SEDW, CWP and SEDW) and 1915(i)SPA operated by the MDHHS. This is based on a 5% margin of error, a 95% confidence level, and a response distribution of 50%. The state then stratifies the sample for each specific waiver by drawing at least a minimum number of records for each waiver. The stratification standards the state uses for minimum sampling is 10% margin of error, 95% confidence level, and a response distribution of 50%.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIC would address QI strategies and systems improvements required for the SEDW, as well as all the waiver populations served by Michigan's mental health system. The QIC also has a formal opportunity to identify issues at a meeting in anticipation of the annual contract renewal. To the extent that the MDHHS/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 MDHHS 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 MDHHS upper management team to revise the QIS. The final decision on changes to the QIS is made by the MDHHS upper management team.

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

In addition, as described in H-1-a-i above, trend patterns identified through a number of quality activities have been used to develop strategies for improvement. Data from site reviews and consultations have been used for systems improvement activities. Examples include: developing workshops for the Annual Statewide Waiver conference, PIHP SEDW lead meetings and identifying topics for technical assistance calls at both state and local levels to address systemic issues.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The SEDW operates concurrently with the State's 1115 Behavioral Health Waiver Demonstration. The SEDW capitation payments are made to the PIHPs for the delivery of waiver services and PIHPs in turn, pays within [and when requested, outside] their networks of contracted providers. There are no fee-for-service payments for waiver services.

a) The MDHHS/PIHP contract includes requirements for PIHPs to complete independent audits.

b) Pursuant to the MDHHS/PIHP and MDHHS/CMHSP contracts, PIHPs and CMHSPs must submit to MDHHS a Financial Statement Audit and a Compliance Examination Report conducted in accordance with the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements 10 and the CMH Compliance Examination Guidelines attached to the MDHHS/PIHP and MDHHS/CMHSP contracts.

The annual independent financial audit must clearly indicate the operating results for the reporting period and financial position of the PIHP at the end of the fiscal year. The Financial Statement Audit must be conducted in accordance with Generally Accepted Auditing Standards.

The annual CMHSP Compliance Examination requires that an independent auditor examine compliance issues related to contracts between PIHPs and the MDHHS to manage the concurrent 1115 Behavioral Health Waiver Demonstration and the 1915(c) waiver programs as well as general fund and Mental Health Block Grant funds. PIHPs must assure that compliance issues are monitored by either requiring their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs or require the affiliated CMHSPs to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. The CMH Compliance Examination does not replace or remove any other audit requirements that may exist, such as a financial statement audit and/or a single audit.

The PIHP must submit to MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end.

PIHPs/CMHSPs are obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the State's BBA-compliant Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: If the code is approved under this contract, eligibility of the beneficiary on the date of service, service is included in the beneficiary's Individual Plan of Service (IPOS), the date/time of service, service provided by a qualified practitioner and falls within the scope of the code billed/paid, amount billed does not exceed the payer's (PIHP or CMHSP) contracted amount, and amount paid does not exceed the payer's (PIHP or CMHSP) contracted amount. Verification procedures must utilize statistically sound sampling methodology in accordance with Office of Inspector General (OIG) standards. PIHP methodology must identify and document the sampling methodology used to determine sampling and describe any tools used to assist in the sample determination process. This process identifies potential issues across persons served including the SEDW population. Any issues identified in this process would be expected to be included in quarterly Program Integrity Activities reports submitted by PIHPs.

In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend \$750,000 or more in federal awards during their fiscal year must submit to MDHHS a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to PIHPs. The 834 process generates an enrollment file based upon the PIHP provider ID number and the beneficiary's assignment to the SEDW Managed Care benefit plan. This process uses edits to assure only the PIHPs that have a contract with the State are provided the capitation payment for the SEDW. Each PIHP has a unique state-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to a contracted PIHP. This process includes verifying the participant's Medicaid eligibility and SEDW benefit plan. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PIHP using the Medicaid Management Information System (MMIS). MDHHS utilizes a six-month retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 process.

The repayment and recoupment processes are for the capture and correction of funds for beneficiaries who enrolled or disenrolled in the PIHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the SEDW during a given month when the PIHP did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for beneficiaries who disenrolled from the SEDW but the PIHPs received capitation payments due to data lags in the 834 process.

c) The PIHPs are responsible for having independent audits completed as noted above. At the state level, the MDHHS Office of Audit and BPHASA/BCCHPS staff review the reports, issue management decisions, and follow-up as needed.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the 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 Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent of capitation payments made to the PIHP only for SEDW participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHP for SEDW participants with active Medicaid eligibility. Denominator: All capitation payments for SEDW participants sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CHAMPS

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

		Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of encounters submitted to MDHHS with all required data elements. Numerator: Number of encounters submitted to MDHHS with all required

data elements. Denominator: Number of all encounters submitted to MDHHS for SEDW participants sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Data Warehouse

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Number and percent of capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Number of capitation payments made to PIHPs at the approved rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS for SEDW participants sampled.

Data Source (Select one):

Other

If 'Other' is selected, specify:

CHAMPS

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

<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> 95
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <input type="text"/>

- 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 MDHHS Site Review includes an examination of the participant's IPOS and the supporting documentation that the services were delivered that were appropriate to the beneficiary's identified needs in the amount, scope, duration and frequency specified in 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.

MDHHS has developed a report in the SEDW database to track and monitor the SEDW beneficiaries not receiving SEDW services on a quarterly basis. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's beneficiaries. For active SEDW beneficiaries not receiving SEDW services in three consecutive months, MDHHS SEDW staff will provide technical guidance with the PIHP and may recommend disenrollment from the SEDW.

MDHHS Office of Audit reviews the Financial Statement Audit and Compliance Examination Reports. The MDHHS will issue a management decision on findings, comments, and questioned costs contained in PIHP Financial Statement Audit and Compliance Examination Report. The management decision relating to the Financial Statement Audit will be issued within six months after the receipt of a complete and final reporting package. The management decision relating to the Compliance Examination will be issued within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the finding or comment is sustained; the reasons for the decision, and the expected Contractor action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, the State may request additional information or documentation from the PIHP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs.

Per the MDHHS/PIHP contract, the PIHP must include program integrity compliance provisions and guidelines in all contracts with subcontracted entities/network providers and if program integrity compliance activities are delegated to subcontractors, the subcontract must comply with the requirements outlined in the MDHHS/PIHP contract. This includes submission of quarterly reports detailing program integrity compliance activities, assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity, provisions for routine internal monitoring of program integrity compliance activities, prompt Response to potential offenses and implementation of corrective action plans, prompt reporting of fraud, waste, and abuse to PIHP and implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities' employees at all levels. For cases of fraud, waste and abuse where it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

If the MDHHS site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Individual remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by MDHHS. Systemic remediations will be reviewed for effectiveness at the next scheduled site review.

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

This §1915(c) waiver operates concurrently with the state's 1115 Behavioral Health Waiver Demonstration. Please refer to the Michigan's approved 1115 Behavioral Health Waiver Demonstration application and associated materials.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The PIHP contracted providers submit SEDW services encounters/claims to the PIHPs; the clean claims are then adjudicated and paid [out of the PIHP's capitation funds] within the payment timeliness parameters specified in their PIHP contracts; the definition of clean claim, the flow of billings, and the payment timeliness parameters, etc. are governed by the MDHHS/PIHP contract.

Current in-scope services for SEDW include Community Living Supports and Respite services. For these services, MDHHS has executed a contract for a State sponsored EVV solution that will operate across all applicable waivers and state plan services. The State sponsored EVV solution includes a pre-billing component to ensure that only clean claims can be successfully adjudicated/processed. Claim submissions that do not pass the pre-billing process will result in a notification being sent through the system indicating that the claim requires correction.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

a) For this waiver, the PIHP incurs certified public expenditures (and is a CMHSP, which is a local government agency).

b) The PIHPs collect and calculate actual cost data and attest to the fact that the data reporting is accurate. Costs are reported through various financial documents both throughout the fiscal year and at the close of the fiscal year and are subject to annual auditing to assure that the CPE is based on total computable costs for the concurrent 1115 Behavioral Health Waiver Demonstration/1915(c) waiver.

c) Expenditures are based on eligibility, reporting of encounters for the provision of valid waiver services and the cost for providing those services. CHAMPS verifies eligibility and checks for encounters. Annual audit compliance exams are used to verify that the CPE are properly identified, categorized, distributed, and reported by fund source are eligible for FFP. MDHHS reviews the annual compliance exam to assure that any irregularities are addressed by the PIHP.

Appendix I: Financial Accountability

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

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

The quarterly CMS 64 Claims for federal financial participation for this waiver program are made based on the monthly §1915(c) waiver capitation payments made to the PIHPs on behalf of the beneficiaries enrolled in this waiver program.

a) These capitation payments are made only after each beneficiary's active Medicaid eligibility has been verified through CHAMPS. Per the performance measure in the QIS for this appendix, a representative random sample of all SEDW beneficiaries is reviewed to assure that capitation payments are made only for SEDW beneficiaries with active Medicaid eligibility.

b) The site review team reviews a proportionate random sample of SEDW beneficiaries during each comprehensive full review. This review includes an examination of the beneficiary's IPOS and the supporting documentation (e.g., progress notes, time sheets, claims from providers to the PIHP, or any other relevant evidence) that the services were delivered that were appropriate to the beneficiary's identified needs in the amount, scope, duration and frequency specified in the IPOS. This is reflected in a performance measure in the QIS for Appendix D.

c) MDHHS developed a report in the SEDW database to track and monitor the SEDW beneficiaries not receiving SEDW services on a quarterly basis. Report will look at SEDW encounters submitted by the PIHP. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's beneficiaries. For active SEDW beneficiaries not receiving SEDW services in three consecutive months, MDHHS will provide phone consultations with the PIHP and may recommend disenrollment from the SEDW.

The MDHHS/PIHP contract specifies the Claims Management requirements incumbent upon the PIHPs and the providers within their networks. It is the encounter and cost data governed by these claims management requirements that constitutes the data basis from which the State's actuary develops the capitation rates for this waiver program's beneficiaries.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds

expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

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

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

As noted in I-1, the SEDW database is the system of record for enrollment into the waiver. On a monthly basis, enrollment data and associated payment elements, such as the residential living arrangement, are interfaced from the SEDW database to CHAMPS. If the SEDW beneficiary is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the SEDW benefit plan is opened. If the SEDW beneficiary is non-Medicaid eligible, notification is sent back to the SEDW database advising that a particular record did not process for payment and must be resubmitted next cycle. If the SEDW benefit plan is open, the PIHP receives an electronic member file containing SEDW enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the SEDW beneficiary has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the SEDW capitation payments are made by MDHHS to the PIHPs' accounts and a payment record is issued to the PIHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

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

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with

efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The PIHPs receive capitation payments and furnish, either directly or through contracts with networks of qualified providers which includes the CMHSPs (who are local governmental entities), the full array of this waiver's services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the 1115 Behavioral Health Waiver Demonstration/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

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

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the 1115 Behavioral Health Waiver Demonstration/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCD; (d) the method(s) for assuring that providers that furnish services under contract with an OHCD meet applicable provider qualifications under the waiver; (e) how it is assured that OHCD contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCD arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

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

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

Appropriation of State Tax Revenues to the State Medicaid Agency

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

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

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Section 428 of the current year Appropriation Act states: Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

a) County governments have the authority to levy taxes. CMHSPs may receive county appropriations or other revenues described below.

b) Per the MDHHS/CMHSP contract, the sources of other revenue are described in Section 7.0 Contract Financing. The revenue sources include county appropriations, other appropriations and service revenues, gifts and contributions, special fund account, investment interest, and other revenues for mental health.

c) The mechanism used to transfer funds to the Medicaid Agency is an intergovernmental transfer, specifically, the PIHP shall provide to MDHHS on a quarterly basis the PIHP obligation for local funds as a bon fide source of match for Medicaid.

Other Local Government Level Source(s) of Funds.

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

Not applicable

Appendix I: Financial Accountability

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

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

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

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability

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

a. **Services Furnished in Residential Settings.** Select one:

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

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home

of the individual.

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

The requirement to exclude room and board costs from Medicaid payments is stated in the Michigan Medicaid Provider Manual, as well as within the MDHHS Contract with the PIHPs. The PIHPs pay for SEDW services. The other costs of the subcontractor residential provider, including room and board, can only be paid by using SSI or state general fund dollars.

Appendix I: Financial Accountability

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

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

No. *The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

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

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

Appendix I: Financial Accountability

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

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

No. *The state does not impose a co-payment or similar charge upon participants for waiver services.*

Yes. *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

i. Co-Pay Arrangement.

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

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

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: 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	5730.50	33236.00	38966.50	153153.00	3602.00	156755.00	117788.50
2	6624.35	38407.00	45031.35	156982.00	3692.00	160674.00	115642.65
3	6888.18	39943.00	46831.18	160906.00	3785.00	164691.00	117859.82
4	7184.93	41694.00	48878.93	164929.00	3879.00	168808.00	119929.07
5	7450.46	43202.00	50652.46	169052.00	3976.00	173028.00	122375.54

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	969		969
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 ALOS has been projected based on actual experience from recent historical experience, reflecting year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count. The ALOS is calculated based on actual experience through December 2023 and estimated phase-in and phase-out assumptions for future time periods. Changes in ALOS over the course of the 5-year renewal period are based on projected changes in enrollees over the waiver period and reflect slightly shorter stays if more people phase into the waiver than phase out in a given year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

We have updated the base utilization and cost per unit experience from the previously filed and approved waiver amendment to reflect SFY 2022 experience. Unless otherwise stated, Factor D for the new 5-year waiver period for the renewal (October 1, 2024 through September 30, 2029) was projected from SFY 2022 of the current period data in the following manner:

- Base number of users was calculated by determining the allocated number of users from the historical experience. The percentage of members identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant counts to determine the number of users across the 5-year renewal period. Therefore, a projected number of users for WY 1 represents projected experience for SFY 2024 multiplied by the change in unduplicated participant count from SFY 2024 to WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology.
- Baseline average units per user was calculated by adjusting the historical experience of average units per user by projected growth in the ALOS. Therefore, a projected average units per user was developed by taking actual experience and multiplying by the change in ALOS to projected future time periods. The change reflected in WY 1 of the renewal period for average units per user was calculated from the projected SFY 2024 average units per user multiplied by the estimated change in ALOS.
- Baseline average cost per unit values were calculated by adjusting the historical experience of unit cost in SFY 2022. Using the total expenditures by waiver service developed from the allocation process and dividing by the total number of units, the cost per unit was established for most of the services. Factor D average cost per unit was trended at a rate of 4.0% per year and select services were further adjusted to account for additional adjustments to account for the increase in direct care worker (DCW) cost increase. The cost per unit values were increased for health maintenance organization costs of 5.0% of the total adjusted cost per unit. Factor D development for the services listed below are exceptions to the methodology outlined above.
- Equine Therapy: Added to Therapeutic Activities
 - o Number of Users – We estimate the number of unduplicated annual users of Therapeutic Activities to increase by 5% (7 users)
 - o Avg. Units Per User – We are assuming the average baseline units (sessions) per user to be 14, consistent with Therapeutic Activities
 - o Avg. Cost/Unit – Average cost per unit was estimated at \$80 and informed by fee schedule assumptions in other states
- Removal of Wraparound Services from the SEDW service array;
- Removal of Family Support and Training services;
- Removal of unit limit for home care training services by a provider at the Bachelor's level;
- o Avg. Cost/Unit – Average cost per unit estimated to increase by 0.7% and informed by average units by month.
- o Removal of Parent Support Partner from Home Care Training, Family services.
- o Number of Users – We estimated the number of unduplicated annual users of parent support partner of approximately 130 based on SFY 2022 experience, trended to SFY 2025 to align with the change in total unduplicated participants assumed in WY 1.
- o Avg. Units Per User – We estimated approximately 9 average units per user of parent support partner based on SFY 2022 experience, trended to SFY 2025 to align with the change in average length of stay assumed in WY 1.
- o Avg. Cost/Unit – We estimated approximately \$269 average cost per unit of parent support partner based on SFY 2022 experience, trended to SFY 2025 for trend and administrative adjustments assumed in the development of WY 1 costs per unit in other services.
- Removal of requirement for Therapeutic Parents to licensed foster homes
- o Avg. Cost/Unit – Average cost per unit assumed to be \$205.89 to correspond with updates to best practice models.
- Overnight Health and Safety Support - Revisions to eligibility language
- o Number of Users – We estimate the number of unduplicated annual users to be 20% of unduplicated participants in the waiver (194 in SFY 2025)

Transportation activity costs will continue to be included in the rates for those specific waiver services which are identified in each waiver application renewal. Michigan is conducting work outside of the waiver renewal related to the allocation of the costs for non-emergency medical transportation (NEMT) that are currently included in waiver services. Transportation costs are not currently reported separately for waiver services therefore cannot be itemized separately in the J tables. Assessments are a separate service and provided through our State Plan, therefore would not be itemized separately in the J tables.

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:

We have updated the base experience for the Factor D' expenditures from the previously filed and approved waiver amendment to reflect SFY 2022 experience. Factor D' was trended at a rate of 4.0% per year.

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:

We have updated the Factor G and G' expenditures for Waiver Years 1 through 5 to be based on Michigan experience for the Hawthorn state inpatient psychiatric facility. Factor G was trended at a rate of 2.5% per year and Factor G' was trended at a rate of 2.0% per year. The trend rate for D and D' are higher than G and G' given Michigan's historical direct care worker trends have been higher than the national average.

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:

We have updated the Factor G and G' expenditures for Waiver Years 1 through 5 to be based on Michigan experience for the Hawthorn state inpatient psychiatric facility. Factor G was trended at a rate of 2.5% per year and Factor G' was trended at a rate of 2.0% per year. The trend rate for D and D' are higher than G and G' given Michigan's historical direct care worker trends have been higher than the national average.

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	
Financial Management Services	
Children's Therapeutic Family Care	
Community Living Supports	
Home Care Training, Family	
Home Care Training, Non-Family	
Overnight Health and Safety Support	
Therapeutic Activities	
Therapeutic Overnight Camp	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent section 1915(b)/section 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:							1217270.34
Respite - 15 minutes		15 minutes	247	627.00	7.86	1217270.34	
Financial Management Services Total:							24635.52
Financial Management Services		Month	39	4.00	157.92	24635.52	
Children's Therapeutic Family Care Total:							132638.76
Children's Therapeutic Family Care		Per Diem (day)	6	102.00	216.73	132638.76	
Community Living Supports Total:							1927502.50
Community Living Supports		15 minutes	250	589.00	13.09	1927502.50	
Home Care Training, Family Total:							458828.91
Home Care Training, Family		Encounter	179	9.00	284.81	458828.91	
Home Care Training, Non-Family Total:							1132.28
Home Care Training, Non-Family		Encounter	4	1.00	283.07	1132.28	
Overnight Health and Safety Support Total:							1561183.96
Overnight Health and Safety		15 minutes	194	1223.00	6.58	1561183.96	
GRAND TOTAL:							5552851.39
<i>Total: Services included in capitation:</i>							5552851.39
<i>Total: Services not included in capitation:</i>							
<i>Total Estimated Unduplicated Participants:</i>							969
<i>Factor D (Divide total by number of participants):</i>							5730.50
<i>Services included in capitation:</i>							5730.50
<i>Services not included in capitation:</i>							
<i>Average Length of Stay on the Waiver:</i>							243

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support							
Therapeutic Activities Total:							185361.12
Activity Therapy - Art, Music, Recreation, Equine Therapy		Encounter	142	14.00	93.24	185361.12	
Therapeutic Overnight Camp Total:							44298.00
Therapeutic Overnight Camp		Session. One night=one	50	6.00	147.66	44298.00	
GRAND TOTAL:							5552851.39
Total: Services included in capitation:							5552851.39
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							5730.50
Services included in capitation:							5730.50
Services not included in capitation:							
Average Length of Stay on the Waiver:							243

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							1406539.03
Respite - 15 minutes		15 minutes	247	697.00	8.17	1406539.03	
Financial Management							25621.44
GRAND TOTAL:							6418996.21
Total: Services included in capitation:							6418996.21
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							6624.35
Services included in capitation:							6624.35
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Financial Management Services		Month	39	4.00	164.24	25621.44	
Children's Therapeutic Family Care Total:							152821.20
Children's Therapeutic Family Care		Per Diem (day)	6	113.00	225.40	152821.20	
Community Living Supports Total:							2225235.00
Community Living Supports		15 minutes	250	654.00	13.61	2225235.00	
Home Care Training, Family Total:							530198.00
Home Care Training, Family		Encounter	179	10.00	296.20	530198.00	
Home Care Training, Non-Family Total:							1177.56
Home Care Training, Non-Family		Encounter	4	1.00	294.39	1177.56	
Overnight Health and Safety Support Total:							1803338.64
Overnight Health and Safety Support		15 minutes	194	1359.00	6.84	1803338.64	
Therapeutic Activities Total:							220315.84
Activity Therapy - Art, Music, Recreation,		Encounter	142	16.00	96.97	220315.84	
GRAND TOTAL:							6418996.21
<i>Total: Services included in capitation:</i>							6418996.21
<i>Total: Services not included in capitation:</i>							
<i>Total Estimated Unduplicated Participants:</i>							969
<i>Factor D (Divide total by number of participants):</i>							6624.35
<i>Services included in capitation:</i>							6624.35
<i>Services not included in capitation:</i>							
<i>Average Length of Stay on the Waiver:</i>							270

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equine Therapy							
Therapeutic Overnight Camp Total:							53749.50
Therapeutic Overnight Camp		Session. One night=one	50	7.00	153.57	53749.50	
GRAND TOTAL:							6418996.21
Total: Services included in capitation:							6418996.21
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							6624.35
Services included in capitation:							6624.35
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							1463351.50
Respite - 15 minutes		15 minutes	247	697.00	8.50	1463351.50	
Financial Management Services Total:							26646.36
Financial Management Services		Month	39	4.00	170.81	26646.36	
Children's Therapeutic Family Care Total:							158936.76
GRAND TOTAL:							6674646.56
Total: Services included in capitation:							6674646.56
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							6888.18
Services included in capitation:							6888.18
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Childrens Therapeutic Family Care		Per Diem (day)	6	113.00	234.42	158936.76	
Community Living Supports Total:							2313525.00
Community Living Supports		15 minutes	250	654.00	14.15	2313525.00	
Home Care Training, Family Total:							551409.50
Home Care Training, Family		Encounter	179	10.00	308.05	551409.50	
Home Care Training, Non-Family Total:							1224.68
Home Care Training, Non-Family		Encounter	4	1.00	306.17	1224.68	
Overnight Health and Safety Support Total:							1874523.06
Overnight Health and Safety Support		15 minutes	194	1359.00	7.11	1874523.06	
Therapeutic Activities Total:							229131.20
Activity Therapy - Art, Music, Recreation, Equine Therapy		Encounter	142	16.00	100.85	229131.20	
Therapeutic Overnight Camp Total:							55898.50
Therapeutic Overnight Camp		Session. One night=one	50	7.00	159.71	55898.50	
GRAND TOTAL:						6674646.56	
Total: Services included in capitation:						6674646.56	
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:						969	
Factor D (Divide total by number of participants):						6888.18	
Services included in capitation:						6888.18	
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							1528436.00
Respite - 15 minutes		15 minutes	247	700.00	8.84	1528436.00	
Financial Management Services Total:							27711.84
Financial Management Services		Month	39	4.00	177.64	27711.84	
Children's Therapeutic Family Care Total:							165296.40
Children's Therapeutic Family Care		Per Diem (day)	6	113.00	243.80	165296.40	
Community Living Supports Total:							2414080.00
Community Living Supports		15 minutes	250	656.00	14.72	2414080.00	
Home Care Training, Family Total:							573462.30
Home Care Training, Family		Encounter	179	10.00	320.37	573462.30	
Home Care Training, Non-Family							1273.68
GRAND TOTAL:							6962194.82
Total: Services included in capitation:							6962194.82
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							7184.93
Services included in capitation:							7184.93
Services not included in capitation:							
Average Length of Stay on the Waiver:							271

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Home Care Training, Non-Family		Encounter	4	1.00	318.42	1273.68	
Overnight Health and Safety Support Total:							1955512.24
Overnight Health and Safety Support		15 minutes	194	1364.00	7.39	1955512.24	
Therapeutic Activities Total:							238287.36
Activity Therapy - Art, Music, Recreation, Equine Therapy		Encounter	142	16.00	104.88	238287.36	
Therapeutic Overnight Camp Total:							58135.00
Therapeutic Overnight Camp		Session. One night=one	50	7.00	166.10	58135.00	
GRAND TOTAL:						6962194.82	
Total: Services included in capitation:						6962194.82	
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:						969	
Factor D (Divide total by number of participants):						7184.93	
Services included in capitation:						7184.93	
Services not included in capitation:							
Average Length of Stay on the Waiver:							271

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							1582141.21
Respite - 15 minutes		15 minutes	247	697.00	9.19	1582141.21	
Financial Management Services Total:							28821.00
Financial Management Services		Month	39	4.00	184.75	28821.00	
Children's Therapeutic Family Care Total:							171906.90
Children's Therapeutic Family Care		Per Diem (day)	6	113.00	253.55	171906.90	
Community Living Supports Total:							2503185.00
Community Living Supports		15 minutes	250	654.00	15.31	2503185.00	
Home Care Training, Family Total:							596392.20
Home Care Training, Family		Encounter	179	10.00	333.18	596392.20	
Home Care Training, Non-Family Total:							1324.64
Home Care Training, Non-Family		Encounter	4	1.00	331.16	1324.64	
Overnight Health and Safety Support Total:							2027437.74
Overnight Health and Safety Support		15 minutes	194	1359.00	7.69	2027437.74	
Therapeutic							247829.76
GRAND TOTAL:							7219497.45
Total: Services included in capitation:							7219497.45
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							7450.46
Services included in capitation:							7450.46
Services not included in capitation:							
Average Length of Stay on the Waiver:							270

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Activities Total:							
Activity Therapy - Art, Music, Recreation, Equine Therapy		Encounter	142	16.00	109.08	247829.76	
Therapeutic Overnight Camp Total:							60459.00
Therapeutic Overnight Camp		Session. One night=one	50	7.00	172.74	60459.00	
GRAND TOTAL:							7219497.45
<i>Total: Services included in capitation:</i>							7219497.45
<i>Total: Services not included in capitation:</i>							
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							7450.46
<i>Services included in capitation:</i>							7450.46
<i>Services not included in capitation:</i>							
Average Length of Stay on the Waiver:							270