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

December 17, 2014

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

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) approves Michigan's 1915(c) home and community-based services (HCBS) Habilitation Supports Waiver amendment, CMS control number 0167.R05.01. Effective April 1, 2014, this amendment provides waiver services to those Healthy Michigan Program enrollees who meet waiver eligibility requirements. The waiver amendment also includes a Home and Community-Based Settings Transition Plan, in accordance with the HCBS final regulation published on January 16, 2014. The amendment did not affect cost-neutrality of the waiver.

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

Sincerely,

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

cc: Jacqueline Coleman, MDCH
Mindy Morrell, CMCS

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The **State** of **Michigan** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Habilitation Supports Waiver
C. **Waiver Number:MI.0167**
Original Base Waiver Number: MI.0167.
D. **Amendment Number:MI.0167.R05.01**
E. **Proposed Effective Date:** *(mm/dd/yy)*
04/01/14
Approved Effective Date: 12/17/14
Approved Effective Date of Waiver being Amended: 10/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
This amendment will allow Healthy Michigan Plan beneficiaries to receive behavioral health and substance disorder services under Habilitation Supports Waiver (HSW). The MDCH is also submitting a Home and Community Based Settings Transition Plan for HSW to CMS in order to comply with the federal final rule on home and community based settings.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	1.G.
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-4 b.
☐ **Appendix C – Participant Services**	

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

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

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

Specify:
This amendment will allow Healthy Michigan Plan beneficiaries to receive behavioral health and substance disorder services under HSW. The MDCH is also submitting a Home and Community Based Settings Transition Plan for HSW to CMS in order to comply with the federal final rule on home and community based settings.

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

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.0167
Waiver Number:MI.0167.R05.01
Draft ID: MI.014.05.01

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

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

1. Request Information (2 of 3)

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

- ☐ **Hospital**

Select applicable level of care

- ○ **Hospital as defined in 42 CFR §440.10**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
- ○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

- ○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

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

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

1. Request Information (3 of 3)

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

Select one:

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

Check the applicable authority or authorities:

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

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

  Michigan operates the §1915(c) Habilitation Supports Waiver concurrently with the §1915(b)waiver, the Managed Specialty Supports and Services Program. Approval of the §1915(b)waiver was granted by CMS effective May 1, 2010.

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

  - ☑ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☑ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☑ **§1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under §1932(a) of the Act.**

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

  Specify the program:

  Healthy Michigan Plan

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☐ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Originally approved by HCFA effective 10/1/1987, the Habilitation Supports Waiver (HSW) was Michigan's primary vehicle for reducing use of its Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) by allowing a strategic set of long-term services and supports to be delivered in community settings. Since that approval, unduplicated ICF/IID users have dropped from just under 4000 to nearly zero. The HSW now functions as the state's primary vehicle for supporting people in the community by enrolling people who were placed out of the ICF/IID and deflecting those who might otherwise require ICF/IID level of services. The purpose of the Habilitation Supports Waiver (HSW) is to provide community-based services to people with developmental disabilities who, if not for the availability and provisions of HSW services would otherwise require the level of care services provided in an ICF/IID. The goal of the HSW is to enable people with intellectual disabilities who have significant needs and who meet the HSW eligibility requirements to live and fully participate in their communities. The objective is to provide regular Medicaid State Plan and Additional Services through the §1915(b) Managed Specialty Services and Supports Waiver and waiver services through the HSW that address the participant's identified needs.

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

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

Oversight of the HSW is provided by Michigan Department of Community Health (MDCH), which is the Single State Medicaid Agency. Two administrations within MDCH - Behavioral Health and Development Disabilities Administration (BHDDA) and the Medical Services Administration (MSA) have responsibility for operations and payments, respectively. The HSW operates concurrently with the §1915(b) Managed Specialty Supports and Services Program as a managed care program. The HSW is administered locally by the Prepaid Inpatient Health Plans (PIHP) under contract with MDCH. Services are provided by the PIHP, its affiliate community mental health services programs (CMHSPs) if applicable, or its contracted entities. HSW participants may receive any medically necessary services provided under the §1915(b)plan as well as all HSW services. Participants enrolled in the HSW may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

   1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

   2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

   3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed

in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
Michigan obtained input from a number of stakeholders in the development of this renewal application.

As required per 6-J below, notification of intent to renew the HSW was mailed to Tribal Chairs and Health Directors on 04/24/2010. Notification of intent and the approved HSW Waiver Application for 2005-2010 was posted on the

Michigan Department of Community Health's (MDCH) website the same day. Tribal Chairs, Health Directors, providers and other members of the public were invited to submit comments regarding the renewal application to Medicaid.

The HSW Program Manager and Assistant met with the Medicaid Provider Helpline staff to provide an overview of the HSW and to answer questions. This enabled Helpline staff to direct any provider questions to the HSW Program staff and the Medical Services Administration (MSA) for responses.

The Medical Care Advisory Council received notification of intent to renew the HSW via electronic correspondence on 06/02/2010 and was invited to submit comments regarding the renewal application to Medicaid.

Presentations were made to the Developmental Disabilities Performance Improvement Team on 05/12/2010 and 06/09/2010 and the Howell Group on 06/10/2010. These state-level groups focus on services for people with developmental disabilities and are comprised of advocates, providers, and other interested parties. Requests were made for members of the groups to distribute the information to others with whom they work who might want to provide input, including people receiving services and their families.

A presentation was made to the PIHP and CMHSP executives on 06/07/2010. The participants were requested to distribute the information to others with whom they work who might want to provide input, including recipients of mental health services, their families, and providers.

In addition to the activities for securing public input that occurred just prior to the renewal, there are on-going opportunities to provide input that has been considered during the renewal process.

The Michigan Medicaid Provider Manual, which is available on the MDCH website, details the HSW in Section 15 of the Mental Health & Substance Abuse Chapter and is available on the MDCH website. Proposed policy revisions to the HSW are published in "Medicaid Policy Bulletins", posted on the website and distributed to providers and the public for review, comment and concurrence.

Elements of the HSW are covered in trainings, presentations, and conferences, which are conducted throughout the state on a regular basis to a variety of stakeholders including: Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) staff (e.g., HSW coordinators, clinical directors and administrative staff, supervisors, supports coordinators and other clinicians), representatives of Special Education, other service providers, advocacy groups, and people who receive services and their families and friends. Additionally, the HSW Program Manager has conducted trainings state-wide as part of the "After I'm Gone" project sponsored by local Arc Chapters, which is targeted to parents of people with developmental disabilities. These training sessions have provided valuable opportunities for families to describe their experiences and suggestions regarding the HSW and mental health managed care programs for their loved ones.

Feedback from all these sources was incorporated into the development of the waiver renewal application.

HSW Amendment 2014

In July 2014, MDCH sent a notice to Tribal Governments of intent to submit a HSW amendment to allow for Healthy Michigan Michigan Plan beneficiaries to receive behavioral health and substance disorder services through the HSW. In August 2014, MDCH sent the amendment and draft HCB Settings transition plan to stakeholders and posted the documents on the MDCH, BHDDA website for public comment. MDCH also posted a public notice in various newspapers across Michigan and sent out a press release to solicit public comment. MDCH developed a dedicated email address for public comment. A stakeholder meeting was held on August 21, for the state transition plan which included information o the HSW transition plan and HSW amendment. See 8B for public comment and response posted on the MDCH/BHDDA website.

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

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance

Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Coleman

First Name: Jacqueline

Title: Waiver Specialist

Agency: Medical Services Administration, Michigan Department of Community Heatlh

Address: 400 South Pine St

Address 2: P.O. Box 30479

City: Lansing

State: **Michigan**

Zip: 48909

Phone: (517) 241-7172 **Ext:** ☐ **TTY**

Fax: (517) 241-5112

E-mail: colemanj@michigan.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone:

Fax: **Ext:** ☐ **TTY**

E-mail:

8. Authorizing Signature

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

Signature: Stephen Fitton

State Medicaid Director or Designee

Submission Date: Dec 9, 2014

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

Last Name: Fitton

First Name: Stephen

Title: Director

Agency: Medical Services Administration

Address: 400 South Pine Street

Address 2:

City: Lansing

State: **Michigan**

Zip: 48933

Phone:

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

Attachments

E-mail: (517) 335-5007

Attachment #1: Transition Plan

Specify the transition plan for the waiver: FittonS@michigan.gov

There is no need for a transition plan related to the elimination of Chore Services as a separate service since the activities will be covered and reported under another existing service, Community Living Supports (CLS). There will be no adverse impact to beneficiaries who need Chore Services as the activities will still be available through CLS services. This change modifies how the service will be reported to the State by the PIHPs.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Section 1: Assessment
Action Item Description Start Date End Date Sources Key Stakeholders
Align all policies, standards, and requirements with HCBS settings requirements
Evaluate program policies, standards, and requirements to identify any needed changes for full alignment with HCBS settings requirements and identify target dates for necessary revisions. 9/1/14 3/1/15 Licensing standards of Adult Foster Care's (AFC), Provider contract, site review protocols Department of Human Services (DHS), Licensing and Regulatory Affairs (LARA), Office of Recipient Rights (ORR)
Obtain active list of residential settings Behavioral Health and Developmental Disabilities Administration (BHDDA) conducts preliminary assessment of the types of HSW residential settings that Michigan Department of Community Health (MDCH) - Behavioral Health and Developmental Disabilities Administration (BHDDA) can assume complies with CMS HCBS settings requirements and those settings which are provider owned or controlled.

During the preliminary assessment, DCH draws a random proportionate sample that is statistically significant to the 95% confidence level from the participants who live in provider owned and controlled settings. The sample will be used for disseminating the PIHP, provider and beneficiary surveys that are described in item 5-7 of the Assessment section of the transition plan. 8/1/14 8/30/14 Waiver Support Application (WSA) and Data warehouse Residential Living Arrangement (RLA) codes DCH Federal Compliance Section, BHDDA
Obtain active list of nonresidential service types BHDDA conducts preliminary assessment of the types of HSW nonresidential services and the characteristics of the settings.

During the preliminary assessment, DCH draws a random proportionate sample that is statistically significant to the 95% confidence level from the participants who received non-residential services. The sample will be used for disseminating the PIHP, provider and beneficiary surveys that are described in item 5-7 of the Assessment section of the transition plan. 8/1/14 8/30/14 Healthcare Common Procedure Coding System (HCPCS) codes of out of home non vocational, pre vocational, and supported employment services billed to HSW DCH Federal Compliance Section, BHDDA
Submit HSW Waiver Amendment Submit Waiver amendment to Centers for Medicare and Medicaid Services (CMS) following public comment period on transition plan. 9/30/14 9/30/14 CMS Waiver document DCH Federal Compliance Section, BHDDA, Medical Services Administration (MSA)

Develop provider self-assessment tool Developmental Disabilities Institute (DDI), as an independent organization, develops tool as guided by the CMS Exploratory Questions Tool and vetted by key stakeholders, for providers to evaluate conformity to HCBS rules. The self-assessment tool will be sent to the providers of the HSW participants that were chosen in the random sample selection (the sampling methodology is described in item2 and item3 of the Assessment Section). DDI will validate the results of this survey by on site assessments conducted by trained reviewers. Incorporate assessment tool into provider enrollment policy and contracts. 10/1/14 2/28/15 CMS exploratory tool, state developed assessment tools DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider network, Quality Improvement Council (QIC), DDI
Develop beneficiary survey tool DDI, as an independent organization, develops tool as guided by the CMS Exploratory Questions Tool and vetted by key stakeholders, for HSW beneficiaries to evaluate conformity to and compliance with HCBS rules and to represent their experience of the setting. The beneficiary survey tool will be sent to the HSW participants that were chosen in the random sample selection (the sampling methodology is described in item2 and item3 of the Assessment Section). DDI will validate the results of this survey by on site assessments conducted by trained reviewers. Incorporate assessment tool into provider enrollment policy and contracts. 10/1/14 2/28/15 CMS exploratory tool, state developed assessment tools DCH Federal Compliance and contracts Section, BHDDA, MSA, HSW beneficiary, DDI.
Develop Community Mental Health (CMH)/ Prepaid Inpatient Health Plan (PIHP) survey tool DDI, as an independent organization, develops tool as guided by the CMS Exploratory Questions Tool and vetted by key stakeholders, for HSW PIHP coordinators to evaluate conformity to and compliance with HCBS rules. The CMH/PIHP survey tool will be sent to all PIHPs of the HSW participants that were chosen in the random sample selection (the sampling methodology is described in item2 and item3 of the Assessment Section). DDI will validate the results of this survey by on site assessments conducted by trained reviewers. Incorporate assessment tool into provider enrollment policy and contracts. 10/1/14 2/28/15 CMS exploratory tool, state developed assessment tools DCH Federal Compliance and contracts Section, BHDDA, MSA, HSW PIHP coordinators, DDI.
Survey tools will be administered and completed. Provider, beneficiary, and CMHSP/PIHP survey tools will be administered and completed. 3/1/15 3/31/15 State developed survey tools DCH Federal Compliance and Performance Measurement Section

Action Item Description Start Date End Date Sources Key Stakeholders
Survey results are submitted to DCH All active enrolled HCBS provider and HSW PIHP coordinators will submit the assessment tool to MDCH. HSW enrollees will be given the opportunity to submit the assessment tool, with assistance from their family and other natural supports, to MDCH however will not be required to do so. Survey will include a prompt to indicate the relationship of the person assisting, as appropriate. 4/1/15 4/30/15 Assessment tool, Provider Network, PIHP HSW coordinators, beneficiary. DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider network, QIC
Assessment data is compiled and analyzed MDCH compiles the data from providers, beneficiary, and PIHP HSW coordinators to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance.

5/1/15 5/30/15 Self-Assessment tool, SharePoint, data analysis DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider network, QIC
Assessment results and report MDCH will present the results of the assessment data to stakeholders and post results.

6/1/15 6/30/15 Self-Assessment tool, SharePoint, data analysis DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider network, QIC

HSW Transition Plan BHDDA will develop a modified Transition Plan informed by the assessment and site survey data which establish a plan for addressing all components of compliance with the HCBS rule.

6/1/15 6/30/15 Assessment results, key stakeholder input results DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider network, QIC, advocacy groups.

Section 2: Remediation
Action Item Description Start Date End Date Sources Key Stakeholders
Submit Waiver Plan Amendment to CMS MDCH will submit a waiver amendment that outlines settings which meet HCBS characteristics and settings which currently do not meet HCBS characteristics but may. The state will design remediation strategies for those HCBS providers not in compliance (but may) with HCBS rules. This amendment will include assessment results and will indicate significant milestones on remediation and a timeline. Settings presumed not to meet HCBS requirements will be identified however the state does not intend to submit a plan to provide evidence that these settings comport to the rule. 6/30/15 6/30/15 CMS HCBS guidelines BHDDA, MSA, PIHP, CMH, Advocates, DHS, LARA, ORR

Design Remedial Strategy BHDDA will design a remedial strategy for settings found to be noncompliant. The remedial strategy steps will include:
• BHDDA will develop a list of those settings that are assumed compliance, out of compliance (but may), and presumed not to meet HCBS rules and submit to CMS.
• The state will include in this process, modifications of relevant policies, laws, or regulations or assisting transfers to acceptable settings.
• For those settings that are out of compliance (but may), remediation will be initiated which will include education and outreach in the form of site surveys, technical assistance and consultation, and corrective action plans.
• For those settings that are presumed not to meet HCBS requirements, the state does not intend to submit a plan to provide evidence that these settings comport to the rule.
- If an HSW participant already residing in the settings that are presumed not to meet HCBS requirements, the PIHP, the participant and his/her representative will develop a transition plan to move to a setting that is in compliance with the HCBS requirements.
- Any new HSW applicant living in a setting that is presumed not to meet HCBS requirements must have a transition plan in place that assures the participant will move to a setting that is in compliance with the HCBS requirements. If there is no transition plan, the first step in the process is to pend the application and request additional information about a transition plan. 10/1/15

6/1/15

10/1/15

6/1/15

6/1/15

6/1/15
12/31/17

6/30/15

3/1/16

12/31/17

12/31/15

12/31/15

CMS HCBS guidelines BHDDA, MSA, Providers, beneficiaries, PIHP, CMH,
Advocates, DHS, LARA, ORR
Policy Development

BHDDA will revise policies and procedures as needed to address ongoing monitoring and compliance, as well as transition plans for all settings that are not in compliance (but may) with the rules, including the self-assessment and survey tools as well as the site review protocols.

10/1/15 3/1/17 DCH and DHS DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider network, QIC, advocacy groups.
DCH site review team will assess for ongoing compliance of HCBS settings in residential and non-residential settings Amend MDCH site review team protocols to include a review of HCBS characteristics in HSW residential and non -residential settings. 10/1/15 3/1/19 Site Review protocols DCH Federal Compliance and contracts Section, BHDDA, MSA, Provider, QIC

Section 3: Outreach and Engagement
Action Item Description Start Date End Date Sources Key Stakeholders
Initial Transition Plan Developed Immediate Stakeholder input gathered by BHDDA 8/1/14 9/30/14 Advocates, General stakeholder meeting
DCH, PIHP, CMH, Advocates, enrollees
Public Notice- Assessment Plan Review MDCH makes public notice calling for comment on the HSW transition plan. The amendment and transition plan were published in major newspapers, DCH website, twitter and Facebook. DCH also sent out L letters to all PIHPs. 8/25/14 9/25/14 HCBS Transition Plan DCH, PIHP, CMH, Advocates, enrollees
Incorporate Public comments- Transition Plan MDCH will collect public comment through dedicated email address, in

person, or via fax. 8/25/14 9/25/14 Dedicated HSW email box DCH
Public Comment- collection and plan revisions MDCH incorporates appropriate changes to Transition Plan based on public comments. 9/26/14 9/28/14 Transition Plan, Public Comments DCH
Public Comment- Ongoing Input MDCH will utilize various stakeholder groups to regularly present and partner with to inform a comprehensive Transition Plan in preparation for Waiver Amendment/Renewal in 2015. 10/1/14 6/30/15 Transition Plan, Public Comments DCH, PIHP, CMH, Advocates, enrollees
Stakeholder education BHDDA will conduct training for individual enrollees of HSW, their circle of support on HCBS rule and impact on their services. Ongoing education for new enrollees and their circle of support will be made available by the appropriate PIHP. 11/1/14 6/30/15 DCH HSW enrollees and circle of support
Provider Education BHDDA will design and implement training and education on HCBS rule 11/1/14 6/30/15 DCH Provider entities

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

A. Stakeholder Input

Comment:

• While I have been aware of and have read information pertaining to the HCBS Final Rule and changes that are anticipated, the Transition Plan, late yesterday was the first I learned of the public comment time frame that concludes today. I therefore am concerned that stakeholders and their families, too, may not have had the information necessary to provide input.

• In our opinion, the opportunity for public comment has been insufficient. Information regarding the opportunity for public comment was not made widely known. We would ask MDCH to make a better effort to gain real and meaningful input from those affected by the plan before submitting it to CMS. One area to improve is in better communicating to key stakeholders the opportunity for public comment.

• While HSW beneficiaries are listed as key stakeholders in developing the assessment tool, the plan is only for the tool to be vetted by key stakeholders. We recommend beneficiaries be a part of the tool development process. Beneficiaries represent a wide array of perspectives and that diversity will play an important role in creating an effective assessment tool. We recommend including a diverse panel of stakeholders representing beneficiaries of varying abilities and preferences in both the development and vetting process.

• Provider respectfully requests MDCH allow more time for stakeholder input in the transition plan. Further, we ask MDCH to seek diverse perspectives in formulating its plan to comply with the CMS Final Rule.

• Stakeholder input for this initial transition plan has been very limited. Our organization is concerned that the Michigan Department of Community Health (MDCH) has not considered or discussed with stakeholders all the issues associated with achieving compliance with the federal final rule for home and community based settings (HCBS rule). Future “stakeholder input processes” must be more robust in order for MALA to support submission of a revised plan in June 2015.

• Parent of adult with autism: with respect to the Habilitation Waiver, who was involved in developing this Waiver Amendment, who should have been getting information about it out to the public?

MDCH Response in no particular order:

• In August, MDCH posted public comment notices in all major newspapers in the State of Michigan and in on two social mediums, Facebook and Twitter. Public Comment letters were also sent out to every PIHP in the state. MDCH distributed the notice at a stakeholder meeting (Howell group) in September. A stakeholder meeting for the State of Michigan transition plan was held which included stakeholders for those enrolled in the HSW. The HSW transition Plan and the amendment were posted on the MDCH website and a dedicated HSW email account was created.

• Per the HSW transition plan, in all stages of the plan (assessment, remediation, and outreach and education) MDCH will utilize various stakeholder groups to regularly present and partner with to inform a comprehensive Transition Plan in preparation for Waiver Amendment/Renewal in 2015. MDCH will amend the transition plan to incorporate obtaining stakeholder input on the development of the survey tool.

• Per the HSW transition plan, providers will be involved in the process of identifying and assessing their settings through the provider assessment tool, as well as providing evidence of ongoing compliance with the HCBS requirements through

their contract with the PIHP.

B. HSW Transition Plan Recommendations

Comment:

• I am hopeful that surveyors establish times to meet with administrators as well as those in the homes where people reside to assure that detailed information regarding inclusion and integration are provided when determining if services provided meet HCBS requirements and expectations.

• The plan seems to be more of a plan to plan, as opposed to the comprehensive plan that the Centers for Medicare and Medicaid Services (CMS) apparently is requesting. Provider organization recommends that a more comprehensive plan be submitted to CMS as part of this current process.

• The sampling process for assessment of residential settings and nonresidential services is clearly inadequate. Provider organization recommends that all the settings and services be assessed to ensure compliance with the federal final rule.

• The plan does not address specifically the requirements for rationale and monitoring of any request for individual deviation from the additional conditions.

• On page 2 of the plan, second row, the "end date" predates the "start date" of the activity. Did you mean a start date of 10.1.2014?

• What criteria will DCH use to assure an organization is truly independent?

• What criteria will DCH use to “assume” a given setting complies with requirements?

• How will DCH assist people with disabilities living in non-compliant settings to move to a setting of their choice?

• Given the current protocol and the staff of 2 that conduct site reviews, the inclusion of this element seems artificial. The current staffing level allows for many people/providers to slip through the cracks. In order for these changes to be genuine more site reviewers should be hired.

• How will DCH outreach to the people living in various residential settings to assure it hears their concerns and recommendations?

• There is a time period of education that end 6/30/15. What appears to be missing is expressed education of new or future HSW enrollees and the education they will receive.

• The timeline in the HSW plan seem much more realistic. The use of an independent organization to validate the results is also a positive. The MICHOICE plan and the HSW plan differ in some areas where consistency would be preferred (i.e. Self -assessment vs. outside assessment).

• The HSW allows for continuous stakeholder input, which the MICHOICE does not.

• The self-assessment to be done by providers is troubling. The rubric will need to be solid and leave no room for interpretation. Why are the MICHOICE assessments being done by agencies and the HSW assessments are self-assessment?

• The transition plan is not written in a way that is accessible to the people who are most affected by the changes, HSW enrollees and their family members. The plan is full of acronyms and jargon that would be challenging to anyone outside "DCH-BHDDA", as the plan refers to it, to interpret. This is troubling. A guide written to explain the jargon to members of the public (since that is whose input is being requested) would be helpful.

MDCH Response in no particular order:

• MDCH submitted a draft HSW transition plan to CMS in August and amended the plan based on their recommendations. This amended plan was the plan posted for public comment.

• CMS guidance allows for the sampling process to occur in assessing compliance with the HCBS requirements.

• Per the transition plan, individual deviations from the rule with regard to settings that do not comply will be identified and a transition plan will need to be developed. With regard to individual "restrictions", it is the expectation that these restrictions will be assessed, documented, and regularly reevaluated through the PCP process.

• On page 2 of the HSW transition plan, second row, the start date was corrected to read 2014 instead of 2015.

• Per CMS guidance, the standards that apply generally to all types of HCBS settings are integration with the community, consumer choice, consumer rights are protected, and consumer independence is optimized. See CMS website for further information at http://medicaid.gov/HCBS.

• The criteria used to determine an independent organization will be an organization that is established as a learning institute which is conflict free of service provision or authorization of services.

• Per the HSW transition plan, an individualized transition plan will be developed by the Prepaid Inpatient Health Plan, for any individual accessing a setting which will not conform to the HCBS requirements.

• A HSW enrollee survey tool will be distributed to individuals living in residential settings (owned or operated by provider). MDCH is working with Adult Foster Care Licensing (BCAL) to determine these settings.

• The HSW transition plan was amended to explain all acronyms.

• The HSW transition plan was amended to include ongoing education for new HSW enrollees.

• An independent organization will be used to validate the results of the stakeholder survey by on site assessments conducted by trained reviewers.

C. HSW Amendment Recommendations

Comment:

• The amendment language excerpted on pages 92 and 93 is from the electronic waiver application form. It appears that the language used is from the previous waiver renewal application that was submitted on an electronic form required by CMS prior to publication of the final HCBS rule. As a result, the draft document under review retains requirements about large settings and the Keys Amendment. This language should be modified since the HCBS rule does not address size. MDCH should provide clarification as to how the language will be changed to address the HCBS rule.

MDCH Response:

• Page 92 to 93 will be amended as a part of the 2015 waiver renewal as guided by the CMS HCBS requirements regarding settings that isolate.

D. Policy & Procedure Recommendations

Comment:

• There appear to be incongruences between the Bureau of Children and Adult Licensing (BCAL) AFC licensing rules. Specialized treatment settings are required to work with individuals that are diagnosed with similar disabilities. HCBS rules define these settings as "segregated," and also directly impacts the ability to offer best practice clinical care.

• Details regarding potential wavier for certain treatment settings, and how they will be determined by the Secretary of HHS. Allowing a waiver will save excess costs to the CMH system.

• Homes where people with developmental disabilities reside are inundated with site reviews, thus I am hopeful that whatever type of site review is determined, that it will take the place of one that currently exists.

• We also have concerns as it relates to licensure of residential treatment programs serving adults with mental illness. Michigan's Adult Foster Care (AFC) licensure was designed to regulate congregate living environments for adults with a variety of disabilities, including settings for adults with mental illness. However, this licensure does not adequately describe a comprehensive residential treatment setting such as ours and others that provide an integrated program of residential care, therapeutic work activity, community integration, and robust clinical services and supports. We strongly believe that the state needs to consider a different type of licensure for these comprehensive programs, so as to differentiate them from those that are only residential care. This could help clarify some of the distinctions outlined in the HCBS Final Rule.

• Many of the guidelines in the Final Rule will be in direct conflict with current Adult Foster Care licensing rules.

• Requiring keyed locks on doors poses serious fire risks. There is also significant risk of lost keys, keys given to inappropriate people, challenges with patients who have PICA and will try to swallow their key.

• Moving people into their own home or apartment with 24 hour staffing puts them at extremely high risk of abuse, neglect or exploitation. These people cannot comprehend their circumstances or report a problem,

MDCH Response in no particular order:

• Per the transition plan, the site review protocols will be amended to address the HCBS requirements and will be incorporated into the current site review schedule.

• MDCH plans to work closely with BCAL (licensing) to align policies and procedures to comply with the HCBS requirements regarding residential settings including health and safety requirements.

E. Person Centered Planning

Comment:

• The HCBS Individual Plan of Service (IPOS) requirements indicate that Community Living Support service providers are not to be part of the process, and may represent a conflict of interested. Since Michigan CMH Boiler Plate contracts require providers to be involved with the IPOS and have timeliness expectations, we are looking to learn more about how to navigate this process.

• I was disappointed to learn in the detail of the HCBS Final Rule that providers will not be invited to PCP meeting regardless of the wishes of the person for whom the plan is held. I believe most administrative personnel employed with provider agencies are represented by people who care deeply about the well-being and happiness of those associated with their organization, thus a blanket rule that does not take into consideration who a person wishes to invite to a meeting is unfathomable. Similarly, the document speaks to congregate settings populated exclusively or primarily with individuals with disabilities living together, this too does not allow choice and preferences of those seeking housing and support.

• Barring providers from Person Centered Plans is going to result in incomplete plans, incompatible goals and lesser services for the person. The person providing the daily care to the person knows them the best.

• I would encourage Michigan's plan strive to not eliminate resources available in our state that are valued by person's served and their families in the effort to meet the final HCBS waiver rule.

• I do not believe it is the intent of this rule to prohibit congregate settings from being considered home and community-based settings. I do know that with thoughtful changes to operational protocol, and perhaps changes to licensure requirements Michigan may be able to avoid ""throwing the baby out with the bath water."" I urge Michigan to utilize the full length of time allowed to create a thoughtful, non-biased approach to coming into compliance with this final rule.

• Separation of the housing provider from the provision of service should be left to informed choice of the program

participant via a true person centered planning process, free of any coercion. I urge Michigan to not structure its service delivery system to promote this separation.

• Eliminating the provider from the person centered planning process can have and will have MANY negative effects on the person served.

MDCH Response:

• MDCH appreciated your comments and concerns however the public comment request is specific to the HCBS settings requirement of the HSW amendment and transition plan which does not include person centered planning.

F. Consumer Choice:

Comment:

• The plan provides no appeal process for an individual to dispute an assessment finding or request a variance. We recommend MDCH make a stronger effort to give the beneficiary a voice in decisions related to his/her services.

• While we certainly do, and always have, supported person centered planning and consumer choice in care setting, we have concerns with some aspects of the HCBS final rule. Sadly, some areas of this rule may actually restrict consumer choice of care settings.

• My sentiments regarding those doing the assessment speak to choice in housing and vocational options as well.

• Lastly, and perhaps most importantly, we have concerns that the restrictions on consumer choice of care setting in the HCBS final rule, and the likelihood of under-funding, will result in an amplification of the existing situation in our communities.

MDCH Response in no particular order:

• State of Michigan with involvement from key stakeholders will develop an assessment tool, as guided by the CMS Exploratory Questions Tool and vetted by key stakeholders, for HSW beneficiaries to evaluate conformity to and compliance with HCBS rules and to represent their experience of both residential and nonresidential settings.

• MDCH continues to support individuals living in the most integrated, person directed environment. The HCBS requirements are focused on the “the participants’ experience” and not solely based on a setting’s location, geography, or physical characteristics. Appeal rights remain per Medicaid rules.

G. Funding

Comment:

• We are concerned with the potential cost to the state, the Community Mental Health organizations and the providers with implementation of the HCBS Final Rule.

• Parent of adult with autism: As the CMH also is having their General Fund dollars cut, and because of the way the Medicaid expansion was done in Michigan, with the Healthy Michigan program not providing the Long Term Care and Supports needed by people with disabilities, how will people like my son, persons with developmental disabilities who have tried but failed at paid employment, be supported in the future under these waivers? If they’re not supported, what if anything, does the state have planned, or are they just left on their own? And if so, what makes Michigan believe that they can do so? Is this a policy choice by the state?

• Parent of adult with autism: Related to the above, if there is no intention at the state level to eliminate the spend down requirement for people so situated as my son and make them eligible based on their development disability and its related needs, what cost benefit analyses were done by the state to determine this was the most feasible option?

MDCH Response:

• MDCH appreciated your comments and concerns however the intent of the public comment for the HSW amendment and transition plan is specific to the HCBS settings rule and cannot address these topics.

H. Other

Comment:

• I would like to express that frequently is it very difficult to obtain assistance for individuals that have Brain Injuries and that this waiver so a better job with including those individuals. Frequently they have physical, cognitive and behavioral problems that are not covered with current CMH funding.

• Treatment settings that meet the needs of individuals on Alternative Leave Status (ALS) from the Center for Forensic Psychiatry have specific details about their ability to access community settings, and would be in conflict with HCBS rulings.

• It is segregation to tell people that they must live in a diverse environment. All over the world people choose to live with other people who are most like them: whether it be based on race, income, nationality, religion or some other common factor. Mandating that people with disabilities must live with other people without disabilities is against their rights.

• Parent of adult with autism: CMS, in a document dated March 16, 2012, entitled "Assuring Access to Affordable Coverage: Medicaid and the Children's Health Insurance Program Final Rule", page 2, states that the final rules "In response to public comment, clarifies that people with disabilities or in need of long-term services and supports may enroll in an existing Medicaid eligibility category to ensure that they are quickly enrolled in coverage that best meets their needs." Has Michigan done that elsewhere if neither of the two waivers referenced in these comments do not do that? If it has not been done anywhere, what are the plans for doing this?

• Parent of adult with autism: Does the state have flow charts available to show what happens when someone like my son comes in the door and asks for services and how they receive waiver services under the two subject documents?

• Parent of adult with autism: I would like to express my concerns about changes currently proposed that will affect how adults with developmental disabilities, adults like my son, will have access to services. It is imperative that any changes to the way in which adults with developmental disabilities are supported include options that allow for unique and innovative programs and residential options.

MDCH Response in no particular order:

• MDCH continues to support individuals living in the most integrated, person directed environment. The HCBS requirements are focused on the "the participants' experience" and not solely based on a setting's location, geography, or physical characteristics.

• Assistance with funding, Medicaid eligibility, and service eligibility for individuals is not a part of this request for public comment and therefore cannot be addressed.

• Treatment settings such as the Center for Forensic Psychiatry would be presumed not to meet the HCBS requirements.

• MDCH will assure that there are a sufficient number of site reviewers available to assess settings.

Appendix A: Waiver Administration and Operation

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

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

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

- **The Medical Assistance Unit.**

  Specify the unit name:

  (Do not complete item A-2)

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

  Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
  Michigan Department of Community Health (MDCH) - Behavioral Health and Developmental Disabilities Administration (BHDDA)
  (Complete item A-2-a).

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

  Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a) The Michigan Department of Community Health (MDCH) is the Single State Medicaid Agency and is comprised of three administrations: The Medicaid Services Administration (MSA), which administers Medicaid for MDCH; the Behavioral Health and Developmental Disabilities Administration (BHDDA), which operates the Habilitation Supports Waiver and other mental health programs; and the Public Health Administration. More specifically, the MDCH-BHDDA performs the following operational and administrative functions: all administrative functions related to the HSW 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, MDCH-BHDDA staff approve or certify some programs, disseminate information concerning the waiver to potential enrollees and service providers, assist individuals in waiver enrollment, manage waiver enrollment against approved limits, monitor waiver expenditures against approved levels, monitor level of care evaluation activities, conduct site reviews, conduct utilization management functions, determine waiver managed care average costs per unit, conduct training and technical assistance (including providing input for updating the Medicaid Provider Manual) concerning waiver requirements and implementation.

   b) The Michigan Medicaid Provider Manual describes roles and responsibilities for waiver operations by the MDCH in the Mental Health and Substance Abuse Chapter. Per the MDCH Organizational Chart, operation of the HSW is within the MDCH-BHDDA Bureau of Community Mental Health Services.

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

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

Appendix A: Waiver Administration and Operation

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

   (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Michigan operates a concurrent §1915(b)/(c) waiver. MDCH 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 18 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 re-certifications; assuring participants have been given freedom of choice of providers and have consented to HSW services in lieu of ICF/IID; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the participant's needs; conducting prior authorization or utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining, monitoring and managing the qualified provider network for managed care and HSW services.

   Michigan utilizes an External Quality Review (EQR) to address PIHP compliance with Balanced Budget Act (BBA) requirements, which includes the concurrent §1915 (b)/(c) waivers. The EQR activities primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented, as well as providing a mechanism for discovering problems and issues at PIHPs/CMHSPs.

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

Appendix A: Waiver Administration and Operation

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

   (●) **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Michigan Department of Community Health (MDCH) - Behavioral Health and Developmental Disabilities Administration (BHDDA) is responsible for assessing the performance of the PIHPs in conducting HSW functions.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Within MDCH-BHDDA, the Division of Quality Management and Planning (QMP) monitors implementation of the concurrent §1915(b) Managed Specialty Supports and Services Program/§1915(c) HSW. This Division also compiles and analyzes encounter data reported by the PIHPs for services delivered to participants receiving §1915(b) and §1915(c) HSW services. The QMP Quality Assurance Section has responsibility for performing on-site reviews at each of the 18 PIHPs. A full on-site review is completed at each PIHP/CMHSP on a biennial basis, with a follow-up review on the alternate year. The Site Review Team reviews a random sampling of HSW participants at each PIHP and any affiliate CMHSPs within a PIHP region as applicable. Those reviews include clinical record reviews and consumer interviews using the Site Review Protocols and Site Review Interpretive Guidelines. The protocols are derived from requirements of the Michigan Mental Health Code, Administrative Rules, federal requirements, and Medicaid policies. The Site Review team monitors the following of the PIHP delegated responsibilities: 1) level of care determinations are made in accordance with HSW eligibility requirements for purposes of recertifying enrollment; 2) individual plans of service (IPOS) meet the HSW participant's identified needs for habilitation; 3) needed services are provided in the amount, scope and duration defined in the IPOS, including any PIHP prior authorization and/or utilization management functions that were part of the allocation of services; and 4) provider qualifications and adequacy of the provider network available for HSW participants. The QMP Division also oversees all quality improvement efforts and ongoing quality assurance by the PIHPs.

   Within MDCH-BHDDA, the Bureau of Community Mental Health Services has responsibility for operation of the HSW on a day-to-day basis. The HSW Program staff, on a continual basis, monitor the following PIHP delegated responsibilities: 1) reviewing and approving initial level of care determinations for enrollment; 2) reviewing quality of initial applications' individual plans of service (IPOS) using person-centered planning (PCP) process and appropriateness for HSW eligibility; 3) reviewing and approving PIHP recommendations for involuntary disenrollments from the HSW; 4) reviewing and consulting with PIHPs when the Site Review Team has identified issues related to the PIHP's level of care determination for continued enrollment; 5) monitoring timeliness of level of care determinations completed at least annually and freedom of choice in lieu of ICF/MR services completed at least every three years; and 6) monitoring health and welfare issues by way of recipient rights complaints, sentinel events, Medicaid fair hearing requests, and the use of restrictive or aversive 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 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 LOC compliance issues that were remediated within 90 days.
Numerator: Number of LOC compliance issues remediated within 90 days.
Denominator: All LOC compliance issues.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: proportionate random sample, 95% Confidence Interval
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of PIHPs that have filled all slots allocated. Numerator: Number of PIHPs that have filled all slots allocated. Denominator: All PIHPs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic record-keeping

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

Data Aggregation and Analysis:

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

Performance Measure:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: proportionate random sample, 95% Confidence Interval
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: proportionate random sample, 95% confidence interval
	☑ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

Data Aggregation and Analysis:

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

		Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: proportionate random sample, 95% confidence interval
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of PIHPs that implement quality assurance/improvement activities as required by contract. Numerator: Number of PIHPs that implement required Q A/I activities. Denominator: All PIHPs.

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

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

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: EQR	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: sampling methodology determined by EQR
	☐ **Other** Specify:	

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

☐ **Other**
Specify:

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Division of Quality Management and Planning (QMP) site review process includes a full review on a biennial basis and a follow-up review in the alternate years. For performance measures related to timely remediation of issues of level of care, plan of service, and qualified providers, the same proportionate random sample used for the review is used. The data source is the plan of correction remediation evidence submitted by the PIHP for any issues identifies during the review of the sample. Timely remediation is completed within 90 days after the PIHP's plan of correction has been approved by MDCH-BHDDA.

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

For the performance measure related to prior authorization, the QMP site review team reviews the proportionate random sample to identify participants where prior authorization was required to determine if the PIHP implemented its prior authorization process as described by its policy.

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

Michigan's concurrent b/c waiver includes a comprehensive quality improvement program that includes HSW participants, but is not exclusive to the HSW. PIHPs are required to submit data on a quarterly basis on Performance Indicators specified by MDCH. These indicators are used to identify trends, outliers, and potentially, may be used for performance improvement programs. The EQR is an additional strategy employed by the State to discover problems and identify trends. EQR activities primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being

implemented. One EQR component addresses PIHP compliance to Balanced Budget Act (BBA) requirements. The other two EQR activities - Performance Improvement Program Validation and Performance Indicators Validation - provide a mechanism for discovering problems / issues.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
As described in a.ii. above, a standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs which are required to submit plans of correction to MDCH-MHSA within 30 days. The plans of correction are reviewed by staff that completed the site review and are subsequently reviewed and approved by MDCH-BHDDA. The PIHP has 90 days after the plan of correction has been approved to provide evidence to MDCH-BHDDA that all issues have been remediated. The remediation process continues until all concerns have been appropriately addressed. If the PIHP is having difficulty meeting the timeframes for remediation, MDCH-BHDDA staff will work with the PIHP to identify strategies to improve timeliness.

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

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

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

ii. Remediation Data Aggregation

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

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

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

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

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	8268
Year 2	8268
Year 3	8268
Year 4	8268
Year 5	8268

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	7902
Year 2	7902
Year 3	7902
Year 4	7902
Year 5	7902

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Enrollment of Priority Groups	

Appendix B: Participant Access and Eligibility

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

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

Enrollment of Priority Groups

Purpose *(describe):*

The MDCH-MHSA retains 8 slots for a temporary enrollment in the HSW for individuals who are prioritized as described in B-3-e. The temporary slots are loaned to a PIHP until the PIHP has a vacancy within its allocation. At that point, the participant is assigned by HSW Program staff into the available PIHP slot and the MDCH-MHSA slot is returned to the pool for re-use.

Describe how the amount of reserved capacity was determined:

In 2007, Michigan began the process of closing its last remaining large ICF/MR facility. In order to assure that people being discharged from the ICF/MR or aging off the Children's Waiver Program (CWP) were able to enroll in the HSW immediately without a delay awaiting a vacancy in the PIHP, the MDCH-MHSA determined that a small bank of slots should be retained at the State to loan temporarily to a PIHP that did not have a vacancy at the time of enrollment. The calculation of 8 slots was based on 1/2% of 160 people (approximately 120 people to exit the ICF/MR total and approximately 40 CWP graduates annually).

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

Waiver Year	Capacity Reserved
Year 1	8
Year 2	8
Year 3	8
Year 4	8
Year 5	8

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

a) Slots are allocated to each of the 18 PIHPs.

b) The methodology for determining the number of slots each PIHP was issued is based on several factors, including the historical demand/use of the Habilitation Supports Waiver when the concurrent §1915(b)/(c) waiver was established; evaluating the penetration rate for each PIHP of persons served with developmental disabilities compared to the number of HSW slots allocated; seeking input from PIHPs that either are requesting additional HSW slots or have unused capacity; and monitoring the usage by PIHP on the HSW database. The distribution of slots among the PIHPs is re-evaluated at least annually or more frequently if necessary. The HSW staff oversee the procedure to assist participants who move from one PIHP to another in order to assure continuity of services. The procedure requires that the current and future PIHP HSW coordinators are notified of the impending move as soon as the move is known. The directors of both PIHPs must submit a letter to the HSW Program Manager indicating their awareness of the move and assuring continuity of services for the HSW participant. At the time of the move, the participant's enrollment is transferred to the new PIHP by way of the HSW database slot allocation report which is controlled by the HSW Program staff at the state level. If there is no vacancy at the new PIHP, the slot is loaned from the current PIHP to the new PIHP by way of the HSW database. As an alternative to a temporary loan/borrow arrangement, the two PIHP directors may also negotiate a permanent transfer of a slot for the participant in writing to the HSW Program Manager.

Highest priority of entrants into the HSW is as follows: 1) people who are currently residing in the Caro Center ICF/IID unit; 2) Children's Waiver Program (CWP) participants who are disenrolling from the CWP at age 18; and then 3) people applying to the HSW who are age 21 and older, who require private duty nursing services and meet all other eligibility requirements for HSW enrollment. As Michigan continues to downsize the ICF/IID unit, the priority will shift from those who are currently residing in the ICF/IID unit to individuals at imminent risk of being placed in the ICF/IID unit as determined through a referral from the MDCH-BHDDA Virtual Team or the Center for Positive Living Supports. The Virtual Team is comprised of State-level employees and consultants with clinical expertise in the areas of psychiatry, nursing, social work, psychology, occupational therapy, and community placement opportunities. The Center for Positive Living Supports is a contracted entity to the MDCH-BHDDA with clinical expertise in psychology, social work, Culture of Gentleness approaches and community placement opportunities for people with significant challenges.

c) There is no unused capacity among the PIHPs at the time of this renewal. Over a period of the past five years, adjustments have been made to the distribution of slots among the PIHPs to a point now where the HSW averages more than 99% full state-wide and nearly every PIHP is at, or very near, 100% capacity on a monthly basis. Adjustments that were made followed the methodology described above in which PIHPs self-reported to MDCH-BHDDA either unused capacity or greater need and slots were re-allocated to assist in meeting these needs. The HSW Program Manager and Assistant monitor slot utilization by PIHP on a monthly basis and work with any PIHPs that are less than 97% filled for three consecutive months by providing technical assistance, regional training, and on-site record reviews to assist staff in identifying and applying for HSW enrollment on behalf of individuals who are eligible.

If a PIHP has no available slots, there may be a wait to apply for the HSW; however, because Michigan operates a concurrent §1915 (b)/(c) waiver, there is no waiting list for mental health services. The Medicaid beneficiary is entitled to receive all medically necessary mental health services using the Speciality Mental Health Supports and Services (b & b3 services). The only exception to this would be for priority group 3 (beneficiary age 21 and older who needs private duty nursing) because private duty nursing is not available in the b-3 services. To ensure no delay in services for those applicants, the state may loan a slot to the PIHP until a vacancy occurs, then move the participant into that PIHP slot and return the loaned slot to the State reserved pool for re-use.

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

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

The selection of entrants into the HSW is made at the state level. As stated previously, because Michigan operates a concurrent §1915(b)/(c) waiver, there is no waiting list for services. Medicaid beneficiaries must receive medically necessary mental health services, regardless of the availability of an HSW slot for that individual.

The procedure for enrollment begins at the PIHP. Each of the 18 PIHPs has an HSW Coordinator, who has primary responsibility for working with supports coordinators and potential enrollees to identify those individuals for whom the PIHP will submit an application. Identification of prospective applicants may come directly from the individual or his/her family requesting the HSW or from the supports coordinator or other staff at the PIHP/CMHSP. Many of the PIHPs have a clinical committee that reviews records to identify those Medicaid beneficiaries who meet the HSW eligibility requirements. The HSW Coordinators have participated in numerous training and technical assistance opportunities and are well-versed in the HSW eligibility requirements. This training enables the HSW Coordinators to be able to explain the waiver and its requirements to clinicians, supports coordinators, prospective applicants and families. In addition, the MDCH/PIHP contract requires that each PIHP have a customer services office, where recipients of mental health services can obtain information on services, including the HSW. If the PIHP determines that an application will be submitted for a Medicaid beneficiary, the HSW Coordinator compiles the required documentation to submit to MDCH-BHDDA. Required documentation consists of a completed HSW certification form, a HIPAA release of information signed by the individual or legal representative, the current plan of services, documentation regarding the person's functional skills (Performance on Areas of Major Life Activities form or equivalent), and any relevant supporting documentation such as professional assessments, individual educational plans (IEP) from schools, or medical reports. If the PIHP determines that an application will not be submitted or will be delayed in submission, the PIHP must give the Medicaid beneficiary an adequate notice of right to fair hearing to appeal that decision.

While a Medicaid beneficiary may wait to apply to the HSW until there is a vacancy, there is no wait list for mental health services available through the Managed Speciality Services and Supports Plan.

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

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

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

If pended, the application is held at the State's HSW Program office, and HSW staff communicate to the PIHP HSW Coordinator about what documentation is lacking via the secure web-based HSW database. An offer is made at that time by the HSW Program staff to provide telephone consultation with the supports coordinator and HSW Coordinator. This process has helped improve understanding of the HSW requirements and facilitated receipt of additional information to continue the enrollment review process. Once the additional information is received, the QMRP again reviews the application and determines whether to approve enrollment or deny. While the application is in pending status, the beneficiary continues to receive all medically necessary mental health §1915 (b) and (b-3) services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

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

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

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

  Select one:

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

  Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **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)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

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

  Pregnant Women
  42 CFR 435.116
  1902(a)(10)(A)(i)(III) and (IV)

1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

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

Specify:

[ ]

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

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

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

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

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

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

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

- **Other**

Specify:

Level of Care (LOC) evaluations and re-evaluations are completed by the PIHPs under contract with MDCH. The PIHPs may delegate this function to a CMHSP affiliate member or a subcontract agency. The MDCH-BHDDA oversees the initial LOC evaluations by reviewing all evaluations and making the final determination of LOC as part of the enrollment into the HSW. Subsequent re-evaluations of LOC are monitored through the site review process and reports generated in the web-based HSW database.

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

The PIHP or its designee evaluate the Medicaid beneficiary's level of care and certify that the person has a developmental disability and would otherwise need ICF/IID level of care but for the availability of HSW services on section 2 of the HSW eligibility certification form. Personnel from the PIHP or its designees with responsibility for conducting the LOC evaluations and reevaluations are Qualified Mental Retardation Professionals (QMRP), as defined in 42 CFR §483.430(a) and the Michigan Medicaid Provider Manual (MPM). The MPM, section 1.7 states that: "A QMRP is a person who has specialized training or one year of experience in treating or working with a person who has mental retardation; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMRP prior to January 1, 2008."

The initial evaluation of the beneficiary's LOC, as submitted by the PIHP, is reviewed and approved as part of the enrollment process by the MDCH-BHDDA HSW Program staff who are QMRPs or who are obtaining QMRP designation under the direct supervision and co-signature of a QMRP.

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

Medicaid beneficiaries evaluated for the HSW must meet the level of care criteria for an ICF/IID as specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. and as identified in the Michigan Medicaid Provider Manual (MPM). This criteria is also included in the "State DD Center Admissions Standards". The MPM states in section 3.13 of the Mental Health and Substance Abuse Chapter: "Beneficiaries must meet ICF/IID level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a qualified mental retardation professional (QMRP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications."

Additionally, Section 15 of the MPM defines eligibility for the HSW. The eligibility requirements that relate to level of care include: The person must have a developmental disability (as defined by Michigan law), and if not for the HSW services, would otherwise require ICF/IID level of care services.

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

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Initial evaluation of LOC may be completed at any time by the PIHPs at the request of a Medicaid beneficiary or when professional assessments identify a potential need for HSW services. When vacancies are available at the PIHP, the HSW Coordinator will submit the LOC evaluation as part of the HSW application. Applications received prior to the 16th of the month are processed for enrollment that month; applications received on and after the 16th of the month are processed for enrollment in the following month. Applications for the groups identified for prioritizaion are reviewed within five working days and if there is an emergency need to enroll a beneficiary who requires private duty nursing and without enrollment into the HSW would be at risk for health and welfare, the application is reviewed within one working day. If an application is pended for additional information, the PIHP must respond within 15 days or request an extension to gather the information. It is in the beneficiary's best interest to allow additional time when the information submitted with the application is insufficient to support enrollment in the HSW. With technical assistance, most applications are approved once the additional information is provided. Also, it should be noted that no beneficiary waits for mental health services while the HSW application is being processed. Services commence immediately upon approval and enrollment in the HSW as the PIHPs have access to real-time enrollment information via the web-based HSW database.

Once the initial determination has been made that the participant has a developmental disability, the subsequent re-evaluations of LOC do not require that the presence of DD be again determined. The PIHP or its designee re-evaluate the Medicaid beneficiary's level of care within a reasonable period of time prior to the expiration of the current evaluation to ensure the re-evaluation is completed within one year of the previous evaluation. The PIHP certifies that the person continues to otherwise need ICF/IID level of care but for the availability of HSW services on section 2 of the HSW eligibility certification form. Personnel from the PIHP or its designee with responsibility for conducting the LOC reevaluations are Qualified Mental Retardation Professionals (QMRP).

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

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

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

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

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

The web-based HSW database tracks timeliness of re-evaluations through several processes and contains edits in the system to prevent user errors on timelines. The PIHP is responsible for entering the re-evaluation dates in the web-based HSW database. The system automatically generates the end-date so the PIHP is always aware of when the

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of intial LOC evaluations that are documented on the HSW certification form. Numerator: Number of initial LOC evaluations that are documented on the HSW certification form at the time of initial application for HSW. Denominator: All LOC evaluations.

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:

Re-evaluation LOC documentation

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of initial LOC evaluations that are completed by a QMRP.
Numerator: Number of initial LOC evaluations that are completed by a QMRP.
Denominator: All LOC evaluations.

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

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

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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.

For initial LOC evaluations, 100% of records will be reviewed by MDCH-BHDDA HSW program staff. For re-evaluations, MDCH-BHDDA HSW program staff will identify a representative random sample for monitoring timeliness of recertification of LOC, as well as whether the PIHP followed the processes and used the correct instruments for LOC determinations. This will done by requesting a copy of the recertification of LOC form from the PIHP in the quarter following when the recertfication was due per the HSW web-based database.

Data regarding re-evaluation may also be drawn from HSW database overdue reports, which are reviewed by the HSW program staff.

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 HSW database is a secure web-based system where users are granted access rights by the HSW Program Manager.

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

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

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

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

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

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

Section 3 of the HSW eligibility Certification form is used to document freedom of choice. The supports coordinator, supports coordinator assistant, or the independent supports broker review and explain the eligibility certification form, as well as the alternatives available to the participant. This section is completed by the participant, legally responsible adult (typically the parent of a minor aged child), legal guardian or other legal representative with authority to make such decisions on behalf of the participant. By signing Section 3 of the form, the participant, family and/or legal representative verifies that they have been informed of their right to choose between the community based services provided by the HSW and the level of care that would be provided in an ICF/IID. The participant or his/her legal representative consent to receiving HSW in lieu of ICF/IID level of care at the time of initial application and give consent at least every three years thereafter. The HSW Eligibility Certification form is maintained in the participant's clinical record at the PIHP. The MDCH-BHDDA retains a copy of the initial certification form that is completed for enrollment into the HSW. During on-site reviews, the State monitors/confirms that choice is offered to participants.

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services

"Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The contract between MDCH and the PIHPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. The contract does specifically require that PIHPs must address cultural differences within its region by making materials available in the langages appropriate to the people served in the area.

In the MDCH/PIHP and MDCH/CMSHP contracts, Section 6.3.3 requires: Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services shall meet the following standards:
1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. All materials shall be available in the languages appropriate to the people served within the PIHP's area. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Vol. 65, August 16, 2002).
3. All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA). Beneficiaries shall be informed of how to access the alternative formats.

The MDCH/PIHP contract, Section 6.4.2 also requires that any subcontracts executed by the PIHP must address compliance with Office of Civil Rights Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency".

Attachment 6.8.2.3 also requires that services must be designed and delivered that respond to an individual’s ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided.

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Out-of-Home Non-Vocational Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Statutory Service	**Supports Coordination**		
Extended State Plan Service	**Enhanced Medical Equipment and Supplies**		

Service Type	Service		
Extended State Plan Service	Enhanced Pharmacy		
Supports for Participant Direction	Goods and Services		
Other Service	Community Living Supports		
Other Service	Environmental Modifications		
Other Service	Family Training		
Other Service	Personal Emergency Response System		
Other Service	Private Duty Nursing		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Out-of-Home Non-Vocational Habilitation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

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

Examples of incidental support include:

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
staffing agency, home care agency or other subcontractor

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Aide

Provider Qualifications

License *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:
The PIHP must verify provider qualifications. If the provider is hired directly by a participant through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
site-based day program operated by CMHSP or other subcontractor

Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Day program sites must be approved by MDCH prior to delivery of services.

Verification of Provider Qualifications

Entity Responsible for Verification:
The PIHP verifies agency qualifications. The agency must assure that all employees delivering the service meet the provider qualifications specified in the Medicaid Provider Manual. If the agency is hired directly by a participant through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

Prevocational services should enable each participant to attain the highest possible wage and work which is in the most integrated setting and matched to the participant's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Support of employment outcomes is a part of the person-centered planning process, and emphasizes informed consumer choice. This process specifies the participant's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the participant's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the participant selects the most cost-effective approach that will help him or her achieve the outcome.

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

Participants participating in prevocational service may be compensated in accordance with applicable Federal

laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation.

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

Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17).

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

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

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

Only activities that contribute to the participant's work experience, work skills, or work-related knowledge can be included in prevocational services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	prevocational support staff
Agency	site-based prevocational program or sheltered workshop operated by CMHSP or other subcontractor

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Individual

Provider Type:
prevocational support staff

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
The support staff must, at a minimum, meet provider qualifications for an aide as specified in the Medicaid Provider Manual. Additionally, the support staff must be knowledgeable about the unique

abilities, preferences, and needs of the individual(s) served and be able to provide services directed toward the outcome of achieving competitive employment.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

site-based prevocational program or sheltered workshop operated by CMHSP or other subcontractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

Respite services may be provided in the following settings that are approved by the participant and identified in the individual plan of services:
- Participant's home
- Home of a friend or relative (not the parent of a minor or the spouse of the participant or the legal guardian)
- Licensed foster care home or respite care facility
- Licensed camp
  •In community settings accompanied by a respite worker
  •Facility approved by the State that is not a private residence, such as group home or licensed respite care facility

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite is not covered if the care is being provided in an institution (i.e., ICF/MR, nursing facility, or hospital) or MDCH approved day program site.

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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Licensed Camp

Provider Qualifications

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

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Human Services Bureau of Children and Adult Licensing

Frequency of Verification:
Initially and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Licensed children's foster care, licensed adult foster care

Provider Qualifications

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

Certificate *(specify):*

N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services Bureau of Children and Adult Licensing
Frequency of Verification:
Initially and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Individual respite provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Aides must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed; in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien); able to perform basic first aid procedures; and is trained in the individual's plan of service, as applicable.
Verification of Provider Qualifications
Entity Responsible for Verification:
The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
staffing agency, home care agency, other PIHP network provider agency
Provider Qualifications
License *(specify):*
If respite is provided by an agency nurse, either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN, the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211
Certificate *(specify):*
N/A

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

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

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

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Independent Nurse (RN or LPN)

Provider Qualifications

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

Certificate *(specify):*

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

Verification of Provider Qualifications

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

Frequency of Verification:
every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Supported employment is the combination of ongoing support services and paid employment that enables the participant to work in the community. For purposes of this waiver, the definition of "supported employment" is:
- Community-based, taking place in integrated work settings where workers with disabilities work alongside people who do not have disabilities.
- For participants with severe disabilities who require ongoing intensive supports such as job coach, employment specialist, or personal assistant.
- For participants who require intermittent or diminishing amounts of supports from a job coach, employment specialist or personal assistant.

Supported employment includes activities needed to sustain paid work by participants receiving waiver services, including supervision and training, job coach, employment specialist services, personal assistance and consumer -run businesses. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services.

Transportation provided between the participant's place of residence and the site of the supported employment service, or between habilitation sites (in cases where the participant receives habilitation services in more than one place), is included as part of the supported employment and/or habilitation service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:
- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- Payments that are passed through to users of supported employment programs;
or
- Payments for vocational training that is not directly related to a participant's supported employment program.

This service must not otherwise be available to the participant through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA), Americans with Disabilities Act (ADA), or Michigan Rehabilitation Services (MRS). Documentation must be maintained by the PIHP that the participant is not currently eligible for work activity or supported employment services provided by MRS. Information must be updated when MRS eligibility conditions change.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	personal assistant
Individual	employment specialist
Individual	job coach

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual

Provider Type:
personal assistant

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
Provider must, at a minimum, meet provider qualifications for an aide as defined in the Medicaid Provider Manual. In addition, the personal assistant must be knowledgeable about the unique abilities, preferences, and needs of the individual, particularly as it relates to supporting the person in his or her job in the community.

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual

Provider Type:
employment specialist

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
An employment specialist must possess skills related to developing job opportunities for participants, including educating the public about employing people with developmental disabilities, working with prospective employers, identifying barriers and helping to resolve those to facilitate employment for the participant. At a minimum, an employment specialist must meet the provider qualifications for an aide as specified in the Medicaid Provider Manual. If the participant's IPOS specifies that the employment specialist must possess additional skills, such as a social worker or occupational therapist, the qualified employment specialist must maintain all relevant state licenses or certifications.

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual

Provider Type:
job coach

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
A job coach must be trained in assisting a participant with work-related activities in the participant's workplace and at a minimum, must also meet provider qualifications for an aide as specified in the Michigan Medicaid Provider Manual.

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Supports Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

6. Assistance with access to entitlements and/or legal representation.

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

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

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

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

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

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators, supports coordinator assistants, or independent supports brokers work closely with the participant to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources. Supports coordination is reported only as face-to-face contact with the participant; however, the function includes not only the face-to-face contact but also related activities (e.g., making telephone calls to schedule appointments or arrange supports) that assure:
- The desires and needs of the participant are determined.
- The supports and services desired and needed by the participant are dentified and implemented.
- Persons chosen by the participant are involved in the planning process.
- Housing and employment issues are addressed.
- Social networks are developed.
- Appointments and meetings are scheduled.
- Person-centered planning is provided and independent facilitation of person-centered planning is made available.
- Natural and community supports are used.
- The quality of the supports and services, as well as the health and safety of the participant, is monitored.
- Income/benefits are maximized.
- Information is provided to assure the participant (and his representative(s), if applicable) is informed about self -determination.
- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided.
- Activities are documented.
- Plans of supports/services are reviewed at such intervals as are indicated during planning.

Additionally, the supports coordinator, supports coordinator assistant, or independent supports broker coordinates with, and provides information as needed to, the qualified mental retardation professional (QMRP) for the purpose of evaluation and reevaluation of participant level of care for eligibility in the HSW.

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. Supports coordination may not duplicate another Medicaid service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The participant cannot receive supports broker services provided by parents (of a minor-aged child) or spouse or legal guardian (of an adult participant). Independent supports broker services may be provided by other relatives of the participant that are not excluded in the preceding sentence.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Supports Broker
Individual	Supports Coordinator Assistant
Agency	Supports Coordinator
Individual	Independent Supports Coordinator

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:
Individual

Provider Type:
Independent Supports Broker

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
1. Chosen by the participant.
2. Minimum of a high school diploma and demonstrated skills and knowledge to perform the functions.
3. Functions under the supervision of a supports coordinator.

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:
Individual

Provider Type:
Supports Coordinator Assistant

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:
Agency

Provider Type:
Supports Coordinator

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. In addition, the agency must maintain a pool of qualified supports coordinators from which the participant can choose. The supports coordinator employed by an agency must be a QMRP as defined in the Michigan Medicaid Provider Manual and maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Verification of Provider Qualifications

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

Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:
Individual

Provider Type:
Independent Supports Coordinator
Provider Qualifications
License *(specify):*
The supports coordinator must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Chosen by the participant.
2. The independent supports coordinator must be a QMRP as defined in the Michigan Medicaid Provider Manual: An individual who meets the qualifications under 42 CFR 483.430. A QMRP is a person who has specialized training or one year of experience in treating or working with a person who has mental retardation; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMRP prior to January 1, 2008.
Verification of Provider Qualifications
Entity Responsible for Verification:
PIHP is responsible for verifying provider qualifications.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Title:
Enhanced Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

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

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

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

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

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

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

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the participant are excluded from coverage.
- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment and Supplies Provider

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Durable Medical Equipment and Supplies Provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

Entity Responsible for Verification:
The PIHP is responsible for verifying provider qualifications.

Frequency of Verification:
prior to contracting with the DMES provider for the item.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Enhanced Pharmacy

HCBS Taxonomy:

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

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
FFP cannot be used to pay for co-pays for other prescription plans the participant may have.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	retailers

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
retailers

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
Retailers must sell the enhanced pharmacy items. Participants may freely select the provider based on location or other factors.

Verification of Provider Qualifications

Entity Responsible for Verification:
PIHP verifies prior to purchase that the retailer sells the item.

Frequency of Verification:
prior to purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Supports for Participant Direction

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

Support for Participant Direction:
Other Supports for Participant Direction

Alternate Service Title (if any):
Goods and Services

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

The

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

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

purpose of the Goods and Services is to promote individual control over and flexible use of the individual budget by the HSW participant using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must (1) increase independence, facilitate productivity, or promote community inclusion and (2) substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support described in HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.

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

Purchase of a warranty may be included when it is available for the item and is financially reasonable.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	goods and services provider

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
goods and services provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

prior to purchasing or contracting to obtain the good or service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote community inclusion and participation. The supports can be provided in the HSW participant's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.) CLS services may not supplant State Plan services, such as Home Help or Expanded Home Help (assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (ADLs) and shopping in the participant's or family's own unlicensed home) and Personal Care (assistance with ADLs in a certified specialized residential setting).

Coverage for Community Living Supports includes:

Assisting, reminding, observing, guiding or training the participant with:

- Meal preparation;
- Laundry;
- Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these activities);
- Activities of Daily Living (ADLs), such as bathing, eating, dressing, personal hygiene;
- Shopping for food and other necessities of daily living.

In addition. CLS Coverage includes:

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The costs associated with room and board are excluded from CLS. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Agency

Provider Type:
home care agency, staffing agency, or other PIHP network provider agency

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Individual

Provider Type:
personal assistant, CLS aide

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:
Agency
Provider Type:
licensed children's foster care, licensed adult foster care
Provider Qualifications
License *(specify):*
Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.14601, R400.15101-.15411, R400.2231-.2246, R400.1151-.1153, R400.1901-1906 and R400.2101-2475, MCL 722.115-118(a)
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Human Services Bureau of Children and Adult Licensing (BCAL)
Frequency of Verification:
Initially and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Physical adaptations to the home and/or workplace required by the participant's individual plan of services (IPOS) that are necessary to ensure the health, safety, and welfare of the participant, or enable him to function with greater independence within the environment(s) and without which the participant would require institutionalization. Adaptations may include:
- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and
- environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers.

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

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

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

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

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

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

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

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

The participant, with the direct assistance by the PIHP supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA) and community development block grants. A record of efforts to apply for alternative funding sources must be documented in the participant's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written

agreement between the landowner, the participant, and the PIHP must specify any requirements for restoration of the property to its original condition if the occupant moves.

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:

Licensed Building Contractor
Provider Qualifications
License *(specify):*
MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3)
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
The PIHP is responsible for verifying provider qualifications
Frequency of Verification:
Prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Training and counseling services for the families of participants served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a participant served on the waiver, and may include a parent, spouse, children, relatives, foster family, unpaid caregivers or in-laws. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the participant at home. All family training must be included in the individual's written plan of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Not included are individuals who are employed to provide waiver services for the participant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse)
Agency	CMHSPs, home care agencies, clinic service agency providers, outpatient clinics

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual

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

Provider Qualifications

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

Certificate *(specify):*

Other Standard *(specify):*
Training must be provided by a professional within the scope of their practice and in good standing with any applicable state and national licensing, certifications, or registrations.

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:
Agency

Provider Type:
CMHSPs, home care agencies, clinic service agency providers, outpatient clinics
Provider Qualifications
License *(specify):*
The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.
Certificate *(specify):*
The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.
Other Standard *(specify):*
Training being provided must fall within the scope of practice of the agency personnel providing the HSW service.
Verification of Provider Qualifications
Entity Responsible for Verification:
The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Medicaid Provider Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency

Provider Type:
PERS provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*

1. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

2. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.

3. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.

4. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Manual. If the participant chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the participant or his/her agent.
Frequency of Verification:
prior to contracting and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Private Duty Nursing (PDN) services consist of skilled nursing interventions to meet the participant's health needs that are directly related to his or her developmental disability. PDN includes the provision of nursing assessment, treatments and observation provided by licensed nurses within the scope of the State's Nurse Practice Act consistent with physician's orders and in accordance with the written health care plan in the participant's record. PIHPs must find that the participant meets Medical Criteria I or II AND III.

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
- Mechanical rate-dependent ventilation four or more hours per day or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or
- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgement and intervention in the rate of oxygen

administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Per Medicaid policy, continuous use oxygen therapy is a covered benefit for participants age 21 or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III below) due to a substantiated medical condition directly related to the developmental disability. For beneficiaries described in Medical Criteria II, the requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care needs. Definitions: "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart condition, would not be considered directly related to the developmental disability. "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The participant requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services. Definitions: "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services. "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
- performing assessments to determine the basis for acting or a need for action and documentation to support the frequency and scope of those decisions or actions;
- managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day;
- deep oral (past the tonsils) or tracheostomy suctioning;
- injections when there is a regular or predicted schedule or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);
- nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
- total parenteral nutrition delivered via a central line and care of the central line;
- continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Per Medicaid policy, continuous use oxygen therapy is a covered benefit for participants age 21 when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below or the PO2 level is 55 mm HG or below;
- monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period as documented in the nursing notes would not be considered skilled nursing.

Once the Medical Criteria eligibility for PDN has been established and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

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

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

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

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

The amount of PDN, i.e., the number of hours, that can be authorized for a beneficiary is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances, e.g., the availability of natural supports; and other resources for daily care, e.g., private health insurance, trusts, bequests.

Licensed nurses provide the nursing assessments, treatments, observation, judgment and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services that includes a health care plan and is maintained in the participant's home. A physician's prescription is required.

These services should be provided to a beneficiary at home or in the community.

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

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

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

The participant receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver:
- Community living supports,
- Out-of-home non-vocational habilitation,
- Prevocational services,
- Supported employment

If a beneficiary is attending school and the Individual Educational Plan (IEP)identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours.

Exceptions to the hours-per-day limit: An exception process to ensure the participant's health, safety and welfare is available if the participant's needs exceed the 16-hours-per-day maximum for a time-limited period

not to exceed six months. Factors underlying the need for additional PDN must be identified in the participant's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:
- current medical necessity for the exception, and
- additional PDN services are essential to the successful implementation of the participant's written IPOS, and are essential to maintain the participant within the least restrictive, safe, and humane environment suitable to his or her condition.

Exceptions must be based on the increased identified medical needs of the participant or the impact on the participant's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the participant's or family's control that place the participant in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:
1. A temporary alteration in the participant's care needs, resulting in one or both of the following:
  - A temporary increase in the intensity of required assessments, judgments, and interventions.
  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the participant's care needs.
The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the participant's increased medical needs for a maximum of six months.

or

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

Definitions: "Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.
"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care. "Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

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

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

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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	private duty nursing agency, home care agency
Individual	Private Duty Nurse (RN or LPN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Agency

Provider Type:
private duty nursing agency, home care agency

Provider Qualifications

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

Certificate *(specify):*
N/A

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

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Individual

Provider Type:
Private Duty Nurse (RN or LPN)

Provider Qualifications

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

Certificate *(specify):*
N/A

Other Standard *(specify):*
It is the LPN's responsibility to secure the services of an RN to supervise his or her work.

Verification of Provider Qualifications

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

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

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

(a)Criminal history/background investigations are completed for all direct care aide-level staff, all clinicians, and other employees providing waiver services in the PIHP provider network panels. PIHPs and those entities/individuals assisting self-directing participants with employer responsibilities perform the investigations prior to hiring aides to perform respite, CLS, and out-of-home habilitation services.

(b) The PIHP or its contracted provider agency is responsible for completing the criminal history/background

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

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

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- (●) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Licensed camp	
Licensed respite care facility	
Licensed adult foster care	
Licensed children's family foster care	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The MDCH-BHDDA has been actively engaged with PIHPs and CMHSPs to identify where people with developmental disabilities live, including HSW participants. MDCH has held discussions with each PIHP and any affiliate CMHSPs regarding their utilization of large settings, activities being implemented to reduce the use of those homes and discussions about how to assure that people have opportunities to live in homelike settings and participate in their communities.

The PIHPs are working with people living in large settings to offer them alternatives to living in their current arrangement. If an HSW participant wants to move from their current home, the PIHP, the participant and his/her representative develop a transition plan to move to a smaller setting. Before, during and after the move, services are maintained at the amount, scope and frequency needed to assure the person's needs, including health and welfare, are met.

In Michigan, the standards required under the Keys Amendment are the Adult Foster Care rules and licensing law, Children's Foster Care family/family group home rules, the Child Care Organization law, and the Public Health Code. Licensing requirements for these homes specify that a home-like character must be maintained. The specific licensing requirements are available on the Michigan Department of Human Services website for the various types of facilities listed in C-2-c-i.

The licensing criteria reflect an attempt to make staying in a group home much like it would be in a home. The rules address such issues as opportunities for the growth and development of a resident; participation in everyday living activities (including participation in shopping and cooking, as desired); involvement in education, employment; developing social skills; contact with friends and relatives; participation in community based activities; privacy and leisure time; religious education and attendance at religious services; availability of transportation; the right to exercise constitutional rights; the right to send and receive uncensored and unopened mail; reasonable access to telephone usage for private communication; the right to have private communications; participation in activities and community groups at the individual's own discretion; the right to refuse treatment services; the right to relocate to another living situation; the right to be treated with consideration and respect; recognition of personal dignity, individuality; the need for privacy; right to access own room at own discretion; protections from mistreatment; access to health care; opportunity for daily bathing; three regular nutritious meals daily; the right to be as independent as the individual may so choose; right to a clean and sanitary environment; adequate personal living space exclusive of common areas; adequate bathroom and facilities for the number of occupants; standard home-like furnishings; and the right to make own decisions.

In addition to Department of Human Services licensing, the PIHP supports coordinator visits regularly to monitor the homelike atmosphere and opportunities for community activities. HSW participants living in group homes may receive additional individualized staff assistance for HSW community-based services, such as out-of-home nonvocational services or to participate in employment opportunities.

Because MDCH-MHSA recognizes the difficulty in providing home and community based services that are unique for a person living in large group settings, MDCH-BHDDA continues to follow its process for HSW enrollments regarding applicants who are living in the largest settings at the time of application to the waiver (for this process, defined as one home with 13 or more beds or a cluster of smaller licensed homes located in proximity as in a campus). Any applicant living in such a facility must have a transition plan in place that assures the participant will move to a smaller home within six months of enrollment. If there is no transition plan, the first step in the process is to pend the application and request additional information about a transition plan. If the applicant chooses to remain in the large setting, the applicant is denied enrollment into the waiver and notice of right to fair hearing is provided. If the applicant subsequently decides to move to a smaller setting, he or she may reapply to the HSW.

During FY11 (waiver year 1), MDCH-BHDDA will develop specific policy that identifies the State's expectations for supporting individuals in their own homes, or in other settings that reflect the characteristics of own home. Those characteristics include not only the "physical plant" but also the degree of the individual's choice and control over what occurs there. Details are in the timelines section of this Appendix.

September 2014:
MDCH plans to work closely with BCAL (licensing) to align policies and procedures to comply with the HCBS requirements regarding residential settings.

Update September 2014:

Per the HCBS requirements effective March 17, 2014, MDCH will follow the guidance provided by CMS on settings that have the effect of isolating individuals receiving HCBS from the broader community and Regulatory Requirements for Home and Community-Based settings and incorporate these changes in the language at the time of the renewal of the HSW in 2015.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed camp

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	☐
Supported Employment	☐
Out-of-Home Non-Vocational Habilitation	☐
Prevocational Services	☐
Respite	☑
Personal Emergency Response System	☐
Environmental Modifications	☐
Community Living Supports	☐
Family Training	☐
Enhanced Pharmacy	☐
Supports Coordination	☐
Enhanced Medical Equipment and Supplies	☐
Goods and Services	☐

Facility Capacity Limit:

more than 4 people

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑

Standard	Topic Addressed
Resident rights	✓
Medication administration	✓
Use of restrictive interventions	✓
Incident reporting	✓
Provision of or arrangement for necessary health services	✓

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed respite care facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	
Supported Employment	
Out-of-Home Non-Vocational Habilitation	
Prevocational Services	
Respite	✓
Personal Emergency Response System	
Environmental Modifications	
Community Living Supports	
Family Training	
Enhanced Pharmacy	
Supports Coordination	
Enhanced Medical Equipment and Supplies	
Goods and Services	

Facility Capacity Limit:

facilities providing respite must meet same capacity limits as children's or adult foster care licensing

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	✓

Standard	Topic Addressed
Physical environment	✓
Sanitation	✓
Safety	✓
Staff : resident ratios	✓
Staff training and qualifications	✓
Staff supervision	✓
Resident rights	✓
Medication administration	✓
Use of restrictive interventions	✓
Incident reporting	✓
Provision of or arrangement for necessary health services	✓

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed adult foster care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	
Supported Employment	
Out-of-Home Non-Vocational Habilitation	
Prevocational Services	
Respite	
Personal Emergency Response System	
Environmental Modifications	
Community Living Supports	✓
Family Training	
Enhanced Pharmacy	
Supports Coordination	
Enhanced Medical Equipment and Supplies	
Goods and Services	

Facility Capacity Limit:

up to 50 - licensing requirements are for homes based on size (family, small, large, congregate)

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	✓
Physical environment	✓
Sanitation	✓
Safety	✓
Staff : resident ratios	✓
Staff training and qualifications	✓
Staff supervision	✓
Resident rights	✓
Medication administration	✓
Use of restrictive interventions	✓
Incident reporting	✓
Provision of or arrangement for necessary health services	✓

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed children's family foster care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	
Supported Employment	
Out-of-Home Non-Vocational Habilitation	
Prevocational Services	
Respite	
Personal Emergency Response System	
Environmental Modifications	
Community Living Supports	✓
Family Training	
Enhanced Pharmacy	

Waiver Service	Provided in Facility
Supports Coordination	☐
Enhanced Medical Equipment and Supplies	☐
Goods and Services	☐

Facility Capacity Limit:

4 or fewer minor children

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision

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

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

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

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

  If a relative who is not the legally responsible individual, i.e., parent of minor child, spouse, or legal guardian, meets the provider qualifications, he or she may be paid for provision of that service. The services that may be provided by a relative are: out-of-home nonvocational habilitation, prevocational (if the relative is employed by the agency, respite, supported employment, supports coordination, community living supports, and private duty nursing. The HSW service descriptions include language that prohibits payment to legally responsible individuals. The PIHPs are responsible for assuring that all providers meet the provider qualifications as specified in the Medicaid Provider Manual for HSW services. The supports coordinator or other provider selected by the participant reviews service logs against planned hours, makes home visits and discusses service provision with the participants and others involved in his/her IPOS to help evaluate congruence between planned and billed hours and the documentation of the types of services delivered as specified in the IPOS.
- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.
- **Other policy.**

  Specify:

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

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

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 applicants for provision of HSW services that meet initial credentialing standards prior to provider enrollment. Numerator: Number of applicants for provision of HSW services that meet initial credentialing standards prior to provider enrollment. Denominator: All new provider applicants for provision of HSW services.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers of HSW services that continue to meet credentialing standards. Numerator: Number and percent of providers of HSW services that continue to meet credentialing standards. Denominator: All providers of HSW services enrolled in the provider network.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of non-licensed, non-certified waiver service providers that meet provider qualifications as stated in the Michigan Medicaid Provider Manual. Numerator: Number of non-licensed, non-certified waiver providers that meet qualifications. Denominator: All non-licensed, non-certified waiver providers.

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of waiver providers that meet staff training requirements. Numerator: Number of waiver service providers that meet staff training requirements. Denominator: All waiver providers.

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The proportionate random sample will look at all providers for a group of HSW participants.

Section 6.4 of the contract between the MDCH and the PIHPs/CMHSPs specifies provider network requirements. The PIHP is responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements to provide services.

The biennial QMP site reviews verify that the PIHP/CMHSPs have documentation of training required by

policy, as published in the Michigan Medicaid Provider Manual. These reviews include discussions with PIHP/CMHSP staff, review of administrative policies and procedures, training, clinical record reviews, interviews with service recipients, and visits to some programs and residential sites.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Any findings noted during the site review process are included in a formal report issued by the MDCH-BHDDA to the PIHP. If an immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP may be required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDCH-BHDDA HSW staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDCH. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
MDCH-BHDDA will develop specific policy identifying the State's expectations for home-like characteristics and access to the community for people living in group homes. To be completed: by 10/1/11. Responsible staff: QMP Division and other assigned staff

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

1. Approximately 60% of individuals enrolled in the HSW are living in settings that are in compliance with the federal HCBS Settings Rule. These settings include living in their own home where their names are on the leases and if they have roommates, have chosen those people who live with them; or living with family members in the home of their relative (non-provider owned or controlled), or living with a foster family where only one or two individuals with disabilities share a home with their foster family. In each of these settings, individuals have full access to the home, such as meals and snacks available at any time, ability to have visitors, having privacy for conducting personal business, and can come and go in the community. These settings allow the participants to be in control of their life and be fully integrated in the community. Per the HSW Transition Plan, the State is in the process of developing a provider self-assessment tool to determine the number and characteristics of non-residential settings that are in compliance with the rule. At the time of this amendment submission, the State has not identified non-residential settings that meet the HCBS Settings Requirements. More information will be available with the submission of the Statewide Transition Plan by January 2015.

2.Currently MDCH has modified the site review protocols in the specialized residential section to incorporate the HCBS requirements. Currently, under the Application for Participation under the Olmstead Comlpiance Section of Community Living, PIHPs are required to provide services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." MDCH will modify its contract with the Prepaid Inpatient Health Plans to require that PIHPs evaluate a statistically significant sample of settings where HSW services are delivered on an on-going basis, as well as evaluate any new providers whose settings will serve HSW participants prior to delivery of HCBS services under the HSW. This includes residential and non-residential settings and will be part of provider network monitoring by the PIHP. For those settings not in compliance, the PIHP will be responsible for working with its provider network to bring those settings into compliance. As noted in the HSW Transition Plan, the State is completing a system-level scan of all licensing rules and regulations, as well as other state laws, rules, etc. that may be involved in settings where HSW is delivered. The State will modify rules, standards, policies, etc. to ensure that all entities that oversee and monitor settings where HSW services are delivered will achieve and maintain compliance with the HCBS through a consistent, coordinated set of standards and policies. MDCH-BHDDA continues to monitor settings as part of its on-site reviews and will be exploring ways to engage stakeholders outside state government to provide monitoring to assure settings are working toward, or maintaining, compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

☑ **Other**

Specify the individuals and their qualifications:

If the participant chooses to not have a case manager/supports coordinator, there are a number of alternatives available for assisting the participant with the development of the IPOS. As defined under supports coordination in Appendix C-1, the participant could also choose a supports coordinator assistant or an independent supports broker to help with developing the IPOS. Qualifications for both types of providers are included in Appendix C-1. If the participant wants another provider instead of a case manager or supports coordinator or supports coordinator assistant or independent supports broker, the PIHP will assist the participant to identify a provider within the network (or enroll a qualified provider upon request if possible) who possesses equal qualifications to a supports coordinator.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process.

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

coordination or case management, the PIHP assists the participant to identify others who are qualified and able to assist with service plan development.

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

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

Person-Centered. The planning process focuses on the participant, not the system or the participant's family, guardian, or friends. The participant's goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the participant wants or needs it, rather than viewed as an annual event.

Outcome-Based. Outcomes in pursuit of the participant's preferences and goals are identified as well as services and supports that enable the participant to achieve his or her goals, plans, and desires. The way for measuring progress toward achievement of outcomes is identified.

Information, Support and Accommodations. As needed, the participant receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the participant to participate in the process are provided.

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

Pre-Planning. The purpose of pre-planning is for the participant to gather all of the information and resources (e.g. people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each participant is entitled to use pre-planning to ensure successful PCP. The following items are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. invite desired participants):
- when and where the meeting will be held,
- who will be invited and who will issue the invitation (including whether the participant has desired meaningful support or if actions need to be taken to cultivate such support),
- what will be discussed,
- what accommodations the participant may need to meaningfully participate in the meeting (including assistance for participants who use behavior as communication),
- who will facilitate the meeting,
- who will record what is discussed at the meeting.

Wellness and Well-Being. Issues of wellness, well-being, health care coordination or integration, and other concerns specific to the participant's personal health goals are discussed and plans to address them are developed. These issues can be addressed outside of the PCP meeting if so desired by the participant.

Participation of Allies. Through the pre-planning process, the participant selects allies (friends, family members and others) to support him or her through the PCP process. Pre-planning and planning help the participant explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and

other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

The plan is developed by the participant with the support of one or more of the following (i) supports coordinator (if desired), or supports coordinator assistant, or independent supports broker (ii) an independent facilitator (if the participant chooses to have one) (iii) Friends, family members, paid staff and others chosen by the participant (collectively called "allies"). A preliminary plan must be developed within seven days of commencement of services [MCL 330.1712 (Michigan Mental Health Code)].

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

The PCP process eliminates the need for many assessments as the participant's needs, preferences goals, and health status are determined through pre-planning and the PCP process. An assessment is conducted to determine functional eligibility for services and supports. The assessments necessary to determine level of care eligibility for the HSW are determined by the PIHP; no standard assessment is required. Most often, a psychosocial assessment is completed. Depending on the individual participant, other assessments may be needed (PT, OT, Speech). Assessment of level of care for HSW eligibility is completed by a QMRP as noted in Appendix B [MDCH Administrative Rule 330.7199].

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

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

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

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

(e) how waiver and other services are coordinated.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Back-up plans provide alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them. All participants who cannot go without their services must develop a back-up plan through the PCP process to plan for the event that a provider may get sick, fail to report to work, or desire to take time off work. Supports coordinators or other PIHP staff should review and approve back-up plans. A copy of the back-up plan should be provided to the participant, left in the participant's home, included in the participant's case record, and given to applicable service providers. Back-up plans include developing lists of alternative qualified providers, using a provider agency, using informal supports, or alerting/contacting the supports coordinator when planned for services are not available. Additionally, emergency plans are developed for each participant that clearly describes a course of action when an emergency situation occurs with the participant. Plans for emergencies are discussed and incorporated into the IPOS during the PCP process. In an effort to make improvements in the way back-up plans are developed with participants, agencies must monitor and track situations in which back-up plans are activated, as well as when they are successful or unsuccessful.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

In Michigan, all Medicaid beneficiaries who are participants in the HSW have a right under the federal Balanced Budget Act (BBA) of 1997 (42 CFR §438.6) to choose the providers of the services and supports that are identified in their individual plan of service (IPOS) "to the extent possible and appropriate." PIHPs or their subcontractors must provide information to participants regarding any restrictions on the participant's freedom of choice among

providers in the network. Qualified providers chosen by the participants but which are not currently in the network or on the provider panel can be added to the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The participant must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances (See 42 CFR §438.52(b)). Choice of providers is essential to ensuring that participants are satisfied with their services and supports and who provides them. For example, most people have strong preferences about who provides their most intimate personal care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The PIHP is responsible for monitoring how the participant implements services and supports, assuring that the funding is expended pursuant to the IPOS and individual budget and that risk management issues are addressed. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as

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

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled participants whose IPOS include services and supports that align with the individual's assessed needs. Numerator: Number of

enrolled participants whose IPOS include services and supports that align with their assessed needs. Denominator: All enrolled participants.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

	two-year time period	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

policies and procedures established by MDCH. Denominator: All IPOS for enrolled participants.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: proportionate random sample
	☑ **Other** Specify: bi-ennial, statewide data gathered over a two-year time period	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver applicants who are offered the choice between receiving waiver services and institutional care prior to initial enrollment in the HSW. Numerator: Number of waiver applicants who are offered the choice between receiving waiver services and institutional care. Denominator: All waiver applicants.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled participants who are offered the choice between receiving waiver services and institutional care. Numerator: Number of enrolled participants who are offered the choice between receiving waiver services and institutional care. Denominator: All enrolled participants.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Re-evaluation LOC documentation

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled participants who are informed of their right to choose among waiver providers. Numerator: Number of enrolled participants who are informed of their right to choose among waiver providers. Denominator: All enrolled participants.

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
A proportionate random sample will be obtained to assure that HSW participants receiving services at each PIHP are reviewed.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Any findings noted during the site review process are included in a formal report issued by the MDCH-BHDDA to the PIHP. If an immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP may be required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDCH-BHDDA HSW staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDCH. In addition to the full site review, the QMP Site Review Team members conduct a follow-up on-site visit approximately one

year after the full site visit to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

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

(a) The nature of the opportunities afforded to participants

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

There are two options for participants choosing to directly employ workers: the Choice Voucher System and Agency with Choice. Through the first option, the Choice Voucher System, the participant is the common law employer and delegates performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Choice Voucher System Technical Advisory. In the Agency with Choice model, participants may contract with an agency with choice and split the employer duties with the agency. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Agency with Choice Technical Advisory. A participant may select one or both options. For example, a participant may want to use the Choice Voucher System to directly employ a good friend to provide CLS during the week and Agency with Choice to provide CLS on the weekends.

(b) how participants may take advantage of these opportunities

Information on the self-determination is provided to all participants who enroll or are currently enrolled in the HSW. Participants interested in arrangements that support self-determination start the process by letting their supports

coordinator or other chosen qualified provider know of their interest. The participants are given information regarding the responsibilities, liabilities and benefits of self-determination prior to the PCP process. An individual plan of service (IPOS) will be developed through this process with the participant, supports coordinator or other chosen qualified provider, and allies chosen by the participant. The plan will include the HSW waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The participant will choose service providers and have the ability to act as the employer. In Michigan, PIHPs provide many options for participants to obtain assistance and support in implementing their arrangements.

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

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

Through its contract with MDCH, each PIHP is required to offer information and education to participants on participant direction. Each PIHP also offers support to participants in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Each PIHP is required to contract with one or more fiscal intermediaries to provide financial management services. Fiscal Intermediary Services is a service in the state's §1915(b) Waiver. The fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements. The fiscal intermediary has four basic areas of performance:
- function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements;
- ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services.
- facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to participant and agency; and
- offer supportive services to enable participants to direct the services and supports they need.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (•) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

(a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction
The PIHPs are responsible for providing information about participant direction opportunities. General information about arrangements that support self-determination is made available to all waiver participants (new and current) by providing them with a general brochure and with directions how to obtain more detailed information. When a person receiving waiver services expresses interest in participating in arrangements that support self-determination, the supports coordinator, supports coordinator assistant, independent supports broker, or other qualified provider as selected by the participant, who has specific training and expertise in the various options available, will assist the participant in gaining an understanding about self-determination arrangements and how those might work for the participant. Many PIHPs have a Self-Determination Coordinator who has expertise in arrangements that would promote self-determination.

Specific options and concerns such as the benefits of participant-direction, participant responsibilities and potential liabilities are addressed through the person-centered planning process, which is mandated in the Mental Health Code. Each participant develops an Individual Plan of Services (IPOS) through the person-centered planning process, which involves his or her allies and a supports coordinator from the PIHP. The IPOS developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. Both the Person Centered Planning Policy and Practice Guideline and the Self-Determination Policy and

Practice Guideline require that health and safety concerns be addressed.

The MDCH-BHDDA provides support and technical guidance to PIHPs for developing local capacity and with implementing options for participant direction. MDCH-BHDDA is currently developing booklets specifically targeted to participants on self-determination and person-centered planning that includes information about the responsibilities, liabilities, and benefits of participant direction.

(b) the entity or entities responsible for furnishing this information
The PIHPs are responsible for disseminating this information to participants, which is done primarily by the supports coordinators, supports coordinator assistants, and independent supports brokers. In addition, the program staff from MDCH-MHSA will provide information and training to provider agencies, advocates and consumers.

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

This information is provided throughout the participant's involvement with the PIHP. It starts from the time that the participant approaches the PIHP for services and is provided with information regarding options for participant direction. Participants are to be provided with information about the principles of self-determination and the possibilities, models and arrangements involved. The PCP process is a critical time to address issues related to participant direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that participant concerns and needs are addressed. Self-determination arrangements begin when the PIHP and the participant reach an agreement on an individual plan of service, the funding authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each participant (or his or her legal representative) who chooses to direct his or her services and supports signs a Self-Determination Agreement with the PIHP that clearly defines the duties and responsibilities of the parties.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

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

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

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

Informal supports, such as non-legal representatives freely chosen by adult participants, can be an important resource for the participant. These informal supports can include agents designated under a power of attorney or other identified persons participating in the PCP process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the participant. Moreover, the §1915(b) waiver service definition of the fiscal intermediary includes the following safeguard: "Fiscal Intermediary Services may not be authorized for use by a participant's representative where that representative is not conducting tasks in ways that fit the participant's preferences and/or do not promote achievement of the goals contained in the person's plan of services so as to promote independence and inclusive community for the participant or when they are acting in a manner that is in conflict with the interests of a participant." In the event the representative is working counter to the participant's interests, the supports coordinator or other chosen qualified provider is authorized to address the issue and work with the participant to find an appropriate resolution.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Private Duty Nursing	✓	✓
Supported Employment	✓	✓
Out-of-Home Non-Vocational Habilitation	✓	✓
Prevocational Services	✓	✓
Respite	✓	✓
Personal Emergency Response System		✓
Community Living Supports	✓	✓
Family Training	✓	✓
Enhanced Pharmacy		✓
Supports Coordination		✓
Goods and Services	✓	✓

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**
☐ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify

the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

☐ **Waiver 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
Private Duty Nursing	☐
Supported Employment	☐
Out-of-Home Non-Vocational Habilitation	☐
Prevocational Services	☐
Respite	☐
Personal Emergency Response System	☐
Environmental Modifications	☐
Community Living Supports	☐
Family Training	☐
Enhanced Pharmacy	☐
Supports Coordination	☐
Enhanced Medical Equipment and Supplies	☐
Goods and Services	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The participant has the freedom to modify or terminate his or her arrangements that support self-determination at any time. The most effective method for making changes is the PCP process in which individuals chosen by the participant work with the participant, supports coordinator, supports coordinator assistant, and broker to determine the necessary challenges and address problems that may be interfering with the success of an arrangement. The decision of a participant to terminate participant direction does not alter the services and supports identified in the IPOS. In that event, the PIHP has an obligation to take over responsibility for assuring the provision of those services through its network of qualified providers.

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		650
Year 2		702
Year 3		744
Year 4		785
Year 5		827

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*:

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

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

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

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The fiscal intermediary is responsible for conducting criminal background checks for directly employed providers. The cost is built into their monthly fee.

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

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

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

Fiscal intermediary is a §1915(b) waiver service and is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the fiscal intermediary to provide financial management services (FMS) and sets the rate and costs for the services. The average monthly fee has ranged from $75.00 to $125.00. Actual costs for the FMS will vary depending on the individual's needs and usage of FMS, as well as the negotiated rate between the PIHP and fiscal intermediary.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the IPOS, using the PCP process, or is determined as applied to a pre-existing, sufficient IPOS, using the PCP process. Budget authorization is contingent upon the participant and the PIHP entity reaching agreement on the amount of the budget and on the methods that will, or may, be applied by the participant to implement the plan and the individual budget. The budget will be provided to the participant in written form, as an attachment to the Self-Determination Agreement that outlines the expectations and obligations of the

participant and the PIHP. The participant's plan is also attached to the agreement.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The State has established a grievance system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 18 PIHPs. The Grievance and Appeal Technical Requirement is Attachment 6.3.2.1 of the MDCH/PIHP concurrent §1915(b)/(c) contract.

The notice of action to the beneficiary or his/her legal representative must be in writing and meet the language format needs of the individual in order that he/she understands the content, (i.e. the format meets the needs of those with limited English proficiency, limited reading proficiency or sensory impairments).

The content of both the adequate and advance notice of action must include:
- An explanation of what action the PIHP has taken or intends to take,
- The reason for the action(s) [42 CFR440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures],
- The beneficiary or his/her legal representative's right to request a State fair hearing and instructions for doing so,
- The beneficiary or his/her legal representative's right to file a PIHP appeal and instructions for doing so,
- The circumstances under which an expedited resolution can be requested and instructions for doing so and
- An explanation that the beneficiary may represent himself or herself or use legal counsel, a relative, a friend or other spokesperson.

An advance notice of action must also include an explanation of the circumstances under which services will be continued pending resolution of the fair hearing or appeal, how to request that benefits be continued and the circumstances under which the beneficiary or his/her legal representative may be required to pay the costs of these services.

Both notices of action must include a Request for Hearing Form (DCH-0092) and a pre-addressed envelope.

If a beneficiary not enrolled in the HSW requests to apply for the HSW, the beneficiary must be given the choice of home and community-based waiver services as an alternative to the level of care provided in an ICF/IID by the PIHP. Evidence that the PIHP offered this choice to the beneficiary is documented in Section 3 of the HSW eligibility certification form. If the PIHP does not offer the choice between home and community-based services instead of the level of care offered by an ICF/MR, the PIHP must give adequate notice to the beneficiary or legal representative (if applicable) per the process described above.

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

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

Upon completion of the development of the individual plan of services (IPOS) through the person-centered planning process, the beneficiary or his legal representative is provided adequate notice of action at the time of the signing that he or she may file a request for a fair hearing if he or she subsequently disagrees with the scope, duration or intensity of authorized services. Adequate notice of action is also provided when there is a decision by the PIHP to deny or limit authorization for services requested. Notice is provided to the beneficiary or his/her legal representative on the same date as the action takes effect.

Advance notice of action is provided/mailed to the beneficiary or his/her legal representative at least 12 days prior to the proposed date the action is to take effect when:
- the PIHP has denied or given limited authorization of a requested service;
- a decision has been made to reduce, suspend or terminate services currently being provided;
- the PIHP has failed to make a standard authorization decision and provide notice of such within 14 days from the date of receipt of the standard request for services;
- the PIHP has failed to make an expedited authorization decision within three working days from the date of receipt of the request for expedited service authorization;
- the PIHP has denied, in whole or in part, payment for a service;
- the PIHP has failed to provide services within 14 days of the start date agreed upon during the person-centered planning process and as authorized by the PIHP;
- the PIHP has failed to act within 45 days from the date of a request for a standard appeal or 3 working days from request of an expedited appeal; or
- the PIHP has failed to provide disposition and notice of a local grievance/complaint within 60 days of the date of the request.

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. (MDCH 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 HSW Program Manager also monitors Fair Hearing Requests and Decisions by the Tribunal for HSW participants and takes action with the PIHP when necessary to assure HSW services are provided as specified in policy.

PIHP Grievance System records must contain sufficient information to accurately reflect:
•The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
•The volume of denied claims for services in the most recent year.

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 18 PIHPs. The Grievance and Appeal Technical Requirement is Attachment 6.3.2.1 of the Medicaid Managed Specialty Supports and Services Concurrent §1915 (b)/(c) Waiver Program Contract.

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

Beneficiary Appeals: Local appeals, like requests for fair hearings, are initiated by notice of an adverse action. The beneficiary or his/her legal representative may request a local appeal concurrently with filing a request for a fair hearing and under the following conditions:
- The beneficiary or his/her legal representative has 45 days from the date of the notice of action to request a local appeal;
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary or his/her legal representative requests expedited resolution;
- The beneficiary or his/her legal representative may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals, e.g. Customer Services, Office of Recipient Rights;
- If the beneficiary or his/her legal representative requests a local appeal not more than 12 days from the date of the notice of action, the PIHP must reinstate or continue the service(s) until disposition of the fair hearing.

When a beneficiary or his/her legal representative requests a local appeal, the PIHP is required to:
- Give the beneficiary or his/her legal representative reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability;

- Acknowledge receipt of each appeal;
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program;
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making;
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal relates to a denial based on lack of medical necessity or involves other clinical issues;
-Provide the beneficiary, or representative with reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing; the opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process; the opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate; information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition of Appeal requirements:
- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include the right to request a state fair hearing, and how to do so; the right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition of Appeal must be provided within the following timeframes:
Standard Resolution: The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed 45 days from the day the PIHP receives the appeal.

Expedited Resolution: The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than three (3) working days after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

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

If the PIHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal make reasonable efforts to give the beneficiary prompt oral notice of the denial, and give the beneficiary follow up written notice within two (2) calendar days.

Beneficiary grievances: Medicaid beneficiaries have the right to a local grievance process for issues that are not "actions". The grievance is filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance. A grievance may be filed at any time by the beneficiary, guardian, or parent of a minor child
or his/her legal representative. For a grievance, the beneficiary would not have access to the state fair hearing process unless the PIHP fails to respond to the grievance within 60 calendar days. This constitutes an 'action", and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:
- give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- acknowledge receipt of the grievance;
- log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program;
- ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making;

- ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance involves clinical issues or involves the denial of an expedited resolution of an appeal (of an action);
- submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination;
- provide the beneficiary a written notice of disposition not to exceed 60 calendar days from the day PIHP received the grievance/complaint. The content of the notice of disposition must include the results of the grievance process, date the grievance process was concluded, the beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and how to access the fair hearing process.

c) The PIHP must provide notice of the right to request a fair hearing to a beneficiary any time there is an adverse action as described in Appendix F-1. As stated previously, the beneficiary may request a Medicaid Fair Hearing concurrently with a request to have the adverse action addressed through the local dispute resolution process. The beneficiary also has the right to request a state fair hearing before exhausting the PIHP level appeal of an "action". The requirements are specified in the MDCH/PIHP contract in Attachment 6.3.2.1.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up

action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

MDCH-BHDDA requires the PIHPs and CMHSPs to report critical incident data and related information as measures of how well the PIHP/CMHSP and its contracted providers monitor the care of vulnerable service recipients, including HSW participants. In order to further enhance its critical incident management system for all recipients of mental health services including HSW participants, Michigan is submitting an action plan to CMS with the HSW renewal application.

IMMEDIATE EVENT REPORTING: Section 6.1.1 of the MDCH/PIHP contract requires the PIHP to report directly to MDCH when any of the following egregious events occur: any consumer death that occurs within 12 months of the individual's discharge from a state facility and/or as a result of suspected staff member action or inaction (report to MDCH electronically within 48 hours of death or PIHP's notification of death), relocation of a consumer's placement due to licensing issues (report to MDCH telephonically or other forms of communication within five business days), conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of his or her job duties or responsibilities (report to MDCH telephonically or by other forms of communication within five business days) and an occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours (report to MDCH telephonically or by other forms of communication within five business days). The CMHSP is responsible to assure the immediate health and welfare of the HSW participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident.

SENTINEL EVENT: Any provider of waiver services report incidents, such as an injury or the use of physical management permitted for intervention in an emergency, on an incident report form that is submitted to the CMHSP. The CMHSP is responsible to assure the immediate health and welfare of the participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident. The PIHP, or its CMHSP affiliate with delegated responsibility, must review the incident to determine if it meets the criteria and definitions for sentinel events and are related to practice of care as described in the G-1-d. The local CMHSP ORR would also receive a copy of the incident report and may also investigate as described in the CMHSP ORR section in G-1-d. If the CMHSP ORR substantiates a rights violation related to abuse or neglect, the ORR makes recommendations for remediation to the CMHSP director. The local CMHSP ORR remediation may become part of the remediation by the PIHP of a sentinel event.

EVENT REPORTING SYSTEM: In an ongoing effort to improve the system of assuring participant safeguards, the new Event Reporting System will be implemented effective 10/1/2010 at the beginning of the waiver approval cycle. This system will enable MDCH to receive data on individual participants within specified timeframes, depending on the type of event. The new ERS requires the PIHP to report the following events to MDCH-BHDDA: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. Timeframes for reporting the five specified events in the ERS are:

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

"best judgment" determination occurred.

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

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

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

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

To assure a smooth transition to the new ERS, the existing sentinel event reporting system described above will continue through waiver year one so both reporting systems will operate during the first year. The change will be reported in the CMS-372 report. In waiver year two, MDCH anticipates eliminating reporting requirements for sentinel events; however, the PIHP will still have responsibility for reviewing incidents to determine those that are sentinel events, investigating and completing the root cause analysis, and implementing remediation through a plan of action or intervention or presentation of rationale for not pursuing an intervention. Incidents will continue to be reported to the CMHSPs as noted above. The PIHP or its designee will review the reported incidents and determine if the incident is 1) a sentinel event that will result in root cause analysis and remediation, and 2) a critical incident that will need to be reported by the PIHP through the new ERS to MDCH.

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

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 DHS CPS for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) "immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this Act (722.623)." Michigan's Social Welfare Act requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) "who suspects or has reasonable cause to believe that an adult has been abused, neglected, or exploited shall make immediately, by telephone or otherwise, an oral report to the county department of social services of the county in which the abuse, neglect, or exploitation is suspected of having or believed to have occurred. After making the oral report, the reporting person may file a written report with the county department [400.11(a)]."

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

(a) The death of a participant.
(b) Any accident or illness that requires hospitalization.
(c) Incidents that involve any of the following:
(i) Displays of serious hostility.
(ii) Hospitalization.
(iii) Attempts at self-inflicted harm or harm to others.
(iv) Instances of destruction to property.
(d) Incidents that involve the arrest or conviction of a participant as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
(2) An immediate investigation of the cause of an accident or incident that involves a participant, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
(3) If a participant is absent without notice, the licensee or direct care staff shall do both of the following:
(a) Make a reasonable attempt to contact the participant's designated representative and responsible agency.
(b) Contact the local police authority.
(4) A licensee shall make a reasonable attempt to locate the participant through means other than those specified in subrule (3) of this rule.
(5) A licensee shall submit a written report to the participant's designated representative and responsible agency in all instances where a participant is absent without notice. The report shall be submitted within 24 hours of each occurrence.
(6) An accident record or incident report shall be prepared for each accident or incident that involves a participant, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
(a) The name of the person who was involved in the accident or incident.
(b) The date, hour, place, and cause of the accident or incident.
(c) The effect of the accident or incident on the person who was involved and the care given.
(d) The name of the individuals who were notified and the time of notification.
(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.
(f) The corrective measures that were taken to prevent the accident or incident from happening again.

Members of the general public may also make reports of incidents of alleged abuse, neglect, exploitation or other concerns. Contact information for local community mental health services programs is available on each CMHSP's website and phone numbers are listed in the phone book. Contact information for the local offices of recipient rights is located on the state ORR's web page. As part of Michigan's action plan, MDCH ORR will review its current web page and work toward designing the page to have a clear link to information for the general public about how and where to report concerns of suspected abuse, neglect or exploitation.

DEFINITIONS:
Definitions of Abuse and Neglect (MDCH Administrative Rule 330.7001):

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

"Abuse class I" means a nonaccidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient.
"Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
"Sexual abuse" means any of the following:
(i) Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
(ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
"Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the

clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in a sexual manner for any of the following:
(i) Revenge.
(ii) To inflict humiliation.
(iii) Out of anger.
"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

"Abuse class II" means any of the following:
(i) A non accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to nonserious physical harm to a recipient.
(ii) The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm.
(iii) Any action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a recipient.
(iv) An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.
(v) Exploitation of a recipient by an employee, volunteer, or agent of a provider.
"Emotional harm" means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
"Exploitation" means an action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.
"Nonserious physical harm" means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.

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

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

Definitions for Sentinel Events:

Sentinel event: An “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (JCAHO, 1998) [excerpt from MDCH-MHSA Guidance on Sentinel Event Reporting (PIHPs)].

Incident: any of the following which should be reviewed to determine whether it meets the criteria for sentinel event
- death of recipient – that which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
- serious illness requiring admission to hospital – does not include planned surgeries, whether inpatient or outpatient, or admissions directly related to the natural course of the person’s chronic illness or underlying condition.
- alleged case of abuse or neglect
- injury from accident or abuse to the recipient requiring emergency room visit or admission to hospital
- serious challenging behavior – those not already addressed in a treatment plan and include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence. Serious physical harm is defined by the Administrative Rules for mental health (300.7001) as “physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient,

caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."
- arrest and/or conviction – any arrest or conviction that occurs with an individual who is in the reportable population at the time the arrest or conviction takes place.
- medication error – a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage, that resulted in death or serious injury or the risk thereof. It does not include instances in which consumers refused medication.

Definitions for ERS:

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

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

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

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

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

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

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

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

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDCH entitled "YOUR RIGHTS When Receiving Mental Health Services in Michigan" at the time of admission into services and periodically thereafter. The HSW participant's supports coordinator will provide information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of HSW services and as often as needed by the participant or the informal caregivers, but at least annually during a person-centered planning meeting. This is in accordance with Section 330.1706 of the Code: "… applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients. From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the Code mandated protections from abuse, neglect, and exploitation, and the how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Chapter 7 of the Michigan Mental Health Code also requires that every CMHSP ORR must assure that all program sites, whether directly operated or through contract with the CMHSP, have rights booklets available in public areas

for consumers, guardians, care-givers, etc. The booklet describes the various rights afforded the individual under the U.S. Constitution, Michigan Constitution, the Michigan Mental Health Code and MDCH Administrative Rules as well as contact information for the CMHSP ORR if the recipient, legal representative, or anyone on behalf of the recipient feels that the recipient's rights have been violated, including the right to be free from abuse or neglect.

Attachment P. 6.3.1.1 of the MDCH-BHDDA/PIHP contract requires that each PIHP must have a Customer Services Unit that provides information about mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a participant. The Customer Services Unit may also, upon request of the participant, assist with contacting the local Office of Recipient Rights for assistance with an issue related to abuse, neglect or exploitation.

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

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

Critical incidents may be investigated by the CMHSP ORR, the PIHP, the CMHSP, as well as by law enforcement or other state agencies as applicable depending on the nature of the incident.

IMMEDIATE EVENT REPORTING: Per Section P 6.7.1.1 of the MDCH/PIHP Contract, following immediate event notification to MDCH (See Section 6.1.1 of contract) the PIHP will submit to MDCH, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service or a death that occurs as a result of suspected staff member action or inaction. 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 ERS to MDCH. In the MDCH/PIHP contract, Section P 6.7.1.1 requires that each PIHP's Quality Assessment Performance Improvement Plan (QAPIP) addresses sentinel events. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. The outcome of this review is a classification of incidents as either sentinel events or non-sentinel events. Sentinel events include: death of the recipient, any accident or physical illness that requires hospitalization, incidents that involve arrest or conviction of the recipient, emergency physical management interventions used for controlling serious challenging behaviors and medication errors (definitions in G-1-b). Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, 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.

Reporting is required for Medicaid beneficiaries who at the time of the event were the responsibility of the PIHP and 1) living in 24-hour specialized settings…; 2) living in their own homes receiving Community Living Supports; or 3) receiving targeted case management…or HSW services… [excerpt from Michigan Mission-Based Performance Indicator System, 6.0, Outcome: Sentinel Events (PIHP)] . Per the MDCH/PIHP Contract Attachment P 1.4.1, physical management, permitted for intervention in emergencies only, is considered a critical incident that must managed and reported according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined in P 1.4.1 as "a technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan." Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The MDCH requires PIHPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the PIHP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. [excerpt from MDCH-BHDDA Guidance on Sentinel Event Reporting (PIHP)]. Sentinel event reporting is submitted in aggregate to MDCH on a quarterly basis.

SENTINEL EVENTS REPORTING: Sentinel event reporting is being phased out at the end of the first year of the waiver renewal and will overlap with the new Event Reporting System (ERS) being implemented effective 10/1/10. This change from sentinel event reporting to the ERS will be reported in the CMS-372 report.

EVENT REPORTING SYSTEM: The new ERS requires the PIHP to report the following events to MDCH-BHDDA: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. CMHSPs will submit data through the PIHP to MDCH-MHSA via the ERS. Incidents reported in the ERS 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 ERS, such as a death or injury, could result in a criminal investigation or referral to Child or Adult Protective Services.

Timeframes for reporting the five specified events in the ERS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the cause of death was determined. For the purpose of the Reportable Events System, a Consumer's death shall be reported as a suicide when either one of the following two conditions exists, the CMHSP serving the consumer determines, through its death review process, that the consumer's death was a suicide, or the official death report (i.e., coroner's report) indicates that the consumer's death was a suicide. If 90 calendar days have elapsed without a determination of cause of death, the CMHSP must submit a "best judgment" determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

Non-suicide death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the CMHSP attempts to determine whether the death was due to suicide. In this case the submission is due within 30 days of the end of the month in which the CMHSP determined the death was not due to suicide.

Emergency medical treatment due to injury or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization due to injury or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Arrest: Due within 60 days after the end of the month in which the arrest occurred.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP affiliates of the PIHPs shall initiate investigation of apparent or suspected

rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the office shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the participant within five days acknowledging receipt of the complaint and then provides written updates every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report of the investigation including the conclusion of the office of recipient rights and the action or plan of action to remedy a violation to the complainant, recipient if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights. Information gathered from investigations is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to CMHSPs. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. As part of Michigan's action plan, MDCH will be revising language in the MDCH/PIHP Contract Attachment P6.7.1.1 to formalize the linkage between the CMHSP ORRs and CMHSPs into the PIHPs' QAPIPs.

OTHER: In the event of a reported incident of a child or adult, DHS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring participant safety. The CMHSP ORR is responsible for investigating rights violations. The DHS BCAL/Adult Foster Care (AFC) Licensing is responsible for investigating licensing rule violations. Law enforcement may also be conducting an investigation related to possible criminal activity in conjunction with the above. Local DHS offices must have signed agreements with their respective CMH boards and AFC licensing to cover roles and responsibilities for handling APS investigations in mental health settings. The protocol for joint operating agreements and the model agreements for this coordination for reporting, investigating and sharing information are in the Adult Services Manual (DHS-ASM 256). As part of Michigan's action plan, a workgroup will be convened to update policies between MDCH and DHS.

If, during a QMP on-site visit, the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

EVENT REPORTING SYSTEM: The ERS will allow MDCH to better monitor the types of events which occur in particular populations, such as the ability to monitor incidents for HSW participants. Since individual consumer identification will be included with each event, MDCH can look for potential trends by comparing reportable events to data already existing in the Quality Improvement/Encounter files. MDCH will oversee that the PIHP delegated responsibility for critical incident management for the waiver population by measuring the rate of critical incidents for HSW participants. After establishing a baseline "penetration" rate (addressed in action plan), MDCH will set targets for reductions in the rate of critical incidents that will result from systems improvement strategies identified in Appendix H and oversight of critical incidents.

MDCH staff reviews the critical incident data for outliers and may contact the PIHP or CMHSP when concerns arise. Technical assistance, consultation, and referrals for additional follow-up or training are provided as required. On-site follow-up on reported events takes place at a maximum during MDCH biennial site reviews. More frequent reviews by MDCH staff may be required in addition to site reviews, depending on the situation. During site reviews, MDCH staff examine the PIHP's event reporting process, their process for conducting root cause analysis on sentinel events, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of reportable event would re-occur. Any noted shortcomings in the PIHP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP within 30 days. The corrective action plan is reviewed by MDCH. If the submitted plan is satisfactory, it is formally approved. Any less than satisfactory plan would be returned to the PIHP for revision and the process for review and approval by MDCH would be repeated until a satisfactory plan is achieved. MDCH conducts an on-site review to assess the efficacy of the plan of correction approximately one year after the full review was conducted. This state oversight by the QMP assures the PIHP has the necessary processes in place for participant safeguards.

The EQR reviews the performance indicator for sentinel event reporting to assure that the QAPIP at each PIHP describes the process for review and follow-up of sentinel events. Because of the nature of sentinel event reporting, a score is given to validate that the processes are in place for review and follow-up. In the most recent report for 2009, 100% of PIHPs had the required processes in place to review and follow-up on sentinel events. MDCH

monitors the EQR report and its recommendations and may follow-up with PIHPs that are outliers in a particular area of the report.

OFFICE OF RECIPIENT RIGHTS: On a semi-annual basis, local CMHSP ORRs report to MDCH the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, right protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDCH include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local 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. It should be noted that starting in fiscal year 2010, each CMHSP rights office must include in its semi- annual and annual complaint data reports to the MDCH Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population, including HSW participants. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

MDCH requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDCH Technical Requirement for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Concurrent §1915(b)/(c) Waiver Program contract between MDCH-BHDDA and the PIHPs; the Agreement Between MDCH-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Human Services Bureau of Child and Adult Licensing (BCAL) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of DHS-BCAL during announced or unannounced inspections and at the time of the biennial licensure process.
Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows:
R 400.14308 Resident behavior interventions prohibitions.

(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(a) Use any form of punishment.
(b) Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDCH-BHDDA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The Michigan Mental Health Code 330.1726 requires (in part):
- A recipient is entitled to unimpeded, private and uncensored communication with others by mail and telephone and to visit with persons of his or her choice;
- The right of a recipient to communicate by mail or telephone or receive visitors shall not be further

limited except as authorized in the person's individual plan of services.
The Michigan Mental Health Code 330.1744 requires (in part):
- The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.
MDCH Administrative Rules 330.7199 requires (in part):
-The plan [of services and supports] shall identify, at a minimum, all of the following:
Any restrictions or limitations of the recipient's rights. Such restrictions, limitations or intrusive behavior treatment techniques shall be reviewed and approved by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. Any restriction or limitation shall be justified, time-limited and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

The MDCH contract with the PIHPs and CMHSPs includes Attachment P 1.4.1 Technical Requirement for Behavior Treatment Plan Review Committees, which addresses the use of restraint, seclusion, and restrictive interventions.

It is the policy of MDCH that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" or "Committee". The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards contained in the Attachment P 1.4.1. 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 licensed psychologist as defined in the Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training and experience in applied behavior analysis; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision making.

The functions of the Committee shall be to:
1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.

Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. 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, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited.

Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term "physical management" does not

include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of a recipient in a prone (face down) position, usually on the floor, where force is applied to the recipient's body in a manner that prevents him or her from moving out of the prone position.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee

2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.

Peer-reviewed literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

Positive Behavior Support: A set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce problem behaviors such as self-injury, aggression, property destruction, pica, defiance, and disruption.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire behavior treatment plan should be reviewed by the Committee.

5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of service recipients.

Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan has been obtained from the individual, the legal guardian, the parent with legal custody of a minor, or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2])

The behavior treatment plan must address the monitoring and staff training to assure consistent

implementation and documentation of the interventions.

The PIHP/CMHSP Behavior Treatment Plan Review Committee must, on a quarterly basis, track and analyze the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
1. Dates and numbers of interventions used.
2. The settings (e.g., group home, day program) where behaviors and interventions occurred
3. Behaviors that initiated the techniques.
4. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
5. Attempts to use positive behavioral supports.
6. Behaviors that resulted in termination of the interventions.
7. Length of time of each intervention.
8. Staff development and training and supervisory guidance to reduce the use of these interventions.

Per Section P1.4.1 of the MDCH/PIHP Contract, physical management is defined as a technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of a recipient in a prone (face down) position, usually on the floor, where force is applied to the recipient's body in a manner that prevents him or her from moving out of the prone position. Physical management is to be used only to address an imminent risk of harm to the individual or others and should be used only for the period of time necessary to ensure health and welfare. Following the use of physical management to address that emergency situation, the sentinel event process begins with root cause analysis and plan of action to prevent use of physical management in the future, which might include revision of the IPOS or review by the Behavior Treatment Review Committee. The use of physical management would also generate an incident report that is reviewed by the CMHSP ORR. If after investigation by the CMHSP ORR, it is determined that staff used physical management (1) when there is not an imminent risk of harm to the recipient or others, (2) if the physical management used is not in compliance with the techniques approved by the CMHSP, (3) the physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service, and/or (4) physical management is used when other lesser restrictive measures were possible but not attempted immediately before the use of physical management, the CMHSP ORR will substantiate Abuse Class II Use of Unreasonable Force, against the staff. The Michigan Mental Health Code mandates that disciplinary action for any substantiated abuse or neglect.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

MDCH monitors the critical incident reporting through the ERS. Any death or injury requiring emergency treatment or hospitalization that resulted from the use of restrictive interventions would be reported within the timeframes specified in G-1-d.

In addition to monitoring critical incident reporting, MDCH-BHDDA oversees the activities of the CMHSP Behavior Treatment Plan Review Committees through quarterly reporting from Committees to MDCH for HSW participants, biennial Site Reviews and more frequent oversight if issues or critical incidents related to the use of restrictive interventions are noted. If critical incidents are reported related to the use of restrictive interventions, MDCH-BHDDA may require the PIHP and CMHSP staff to receive training in the culture of gentleness and positive behavioral supports, as well as recommend other approaches or strategies as appropriate.

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 MDCH 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:

- ○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

  i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

  The PIHPs and their affiliated CMHSPs have ongoing responsibility for "second line" management and monitoring of participant medication regimens ["first line" management and monitoring is the responsibility of the prescribing medical professional]. The participant's individual plan of services and supports must contain complete information about their medications regimen [i.e., what each medication is for; frequency and dosage; signs and symptoms suggesting/requiring attention, etc]. These details and any other monitoring recommendations from the prescribing professional are shared with the members of the participant's planning team [as authorized by the participant], and all provider staff with medication administration/self-administration assistance/monitoring responsibilities. This helps all within the participant's

planning/service/support network to know when to request a formal medication review outside those scheduled within the plan. Supports coordinators' monitoring of participants includes general monitoring of the effectiveness of the participant's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with participants, and discussion with direct care and other staff as appropriate. Supports coordinators average one face-to-face visit per month with HSW participants.

The PIHP/CMHSP medications monitoring procedure, called a Medication Review, is by definition the evaluation and monitoring of medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications. The frequency of regular medication reviews must be specified in the participant's individual plan of services and supports. The average frequency of Medication Reviews performed for those participants who required them is approximately once per quarter.

Michigan's Department of Human Services (DHS) licenses and certifies Adult Foster Care settings that provide specialized residential services. A significant number of HSW participants reside in this type of setting. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. DHS licensing inspections occur every two years, as well as conducting special investigations when needed.

Any use of behavior modifying medications requires specific approval of a Behavior Treatment Plan Review Committee. These requirements are outlined in contracts with the PIHPs and specify committee membership and review requirements are included in G-2-b. Committee reviews of the use of behavior modifying medications must be completed at least quarterly, but may be completed more frequently at the discretion of the committee. Reports from the Committee must be submitted to MDCH for HSW participants on a quarterly basis.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the PIHP must follow-up to address the participant's health and welfare as applicable, report through the ERS and conduct a sentinel event investigation.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

In addition to the state requiring the PIHP/CMHSP precautions outlined in G-3-a.i, the state's specialized residential certification rule R330.1806(2)(e) requires that "all staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas. . .proper precautions and procedures for administering prescriptive and non-prescriptive medications." In addition to the regular Medication Reviews by the PIHP/CMHSP medical professionals specified in the plan, supports coordinators and others are trained to spot signs and symptoms of potentially harmful practices and can request an unscheduled Med Review and a planning meeting to address any confirmed issues.

The State currently requires PIHPs to report medication errors that rise to the level of a sentinel event. This information is reported to MDCH-BHDDA on a quarterly basis through the current sentinel event reporting, which will overlap through FY11 with the new critical incident reporting system effective 10/1/10. This system will capture individually identifiable medication errors that required medical follow-up or hospitalization.

During biennial QMP site reviews of the PIHPs, MDCH-BHDDA staff on the site review team evaluate residential service provider compliance with staff training and incident reporting requirements, as well as the PIHP's monitoring and follow-up of medication errors. In addition, the site reviews evaluate compliance with Behavior Treatment Plan Committee and the sentinel event reporting requirements. The Site Review Team includes registered nurses with experience in the identification of potentially harmful practices. 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 MDCH, 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 recipient’s individual plan of service and based upon the recipient’s clinical status.
(5) If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
(6) A provider shall record the administration of all medication in the recipient's clinical record.
(7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.

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 7158 (7). PIHPs must report certain medication errors to MDCH-BHDDA per the MDCH-BHDDA/PIHP and CMHSP contracts.

"Medication errors" mean: wrong medication; wrong dosage; double dosage; or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which participants have refused medication. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDCH-MHSA when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

For FY11 (waiver year 1), medication errors are reviewed, investigated and acted upon at the local level by each PIHP and reported to MDCH-BHDDA on a quarterly basis when the error is considered a sentinel event. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to MDCH-BHDDA when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm. Also in FY11 (waiver year 1), there is an overlap as the new Event Reporting System (ERS) is implemented, which will provide individual level data on medication errors that resulted in emergency medical treatment or hospitalization. For waiver years 2-5, the ERS will be the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents that are sentinel events and perform root cause analysis and carry out actions to prevent or reduce the likelihood that this type of sentinel event 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.

MDCH will monitor the critical incidents related to medication errors through the ERS to monitor for trends and outliers. MDCH may require the PIHP to receive additional technical assistance or training as a result of ERS data.

On-site follow-up on reported sentinel events regarding medication errors takes place at a maximum during QMP biennial site reviews. During these site reviews, MDCH-BHDDA staff review the PIHP's sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that this type of sentinel event would re-occur. Any noted shortcomings in the PIHP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP and additional follow-up by MDCH 90 days after the corrective action plan has been approved. Post PIHP sentinel event data submission, MDCH-BHDDA staff contacts the PIHPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of critical incidents reported for HSW enrollees.
Numerator: Number of critical incidents reported for HSW enrollees.
Denominator: All HSW enrollees.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # & % of enrollees requiring emergency medical treatment or hospitalization d/t injury related to the use of a restrictive intervention. N: # of enrollees requiring emergency medical treatment or hospitalization d/t injury related to the use of a restrictive intervention. D: all enrollees with reported incidents of emergency medical treatment or hospitalization for injuries or medication errors

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of enrollees requiring emergency medical treatment or hospitalization due to medication error. Numerator: Number of enrollees requiring emergency medical treatment or hospitalization due to medication error. Denominator: all enrollees with reported incidents of emergency medical treatment or hospitalization for injuries or medication errors

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
MDCH will analyze a 100% sample of all reported critical incidents involving HSW participants from the ERS, as well as analyze subcategories of critical incidents reported through the ERS who either required emergency medical treatment or 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 "penetration rate" and targets will be established to measure whether the rates decrease, increase or remain unchanges as policies and approaches are implemented. MDCH is particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effective of preventive strategies.

The CMHSPs submit, on a quarterly basis, aggregate data by event category for number of sentinel events and plans of action or interventions which occurred during the three month period. The Michigan Department of Community Health (MDCH) analyzes the data and prepares a report on the number of sentinel events (by category) per thousand persons served who meet the population definition. As with all performance

indicators, MDCH reviews performance, with potential follow-up by contract managers to determine what quality improvement action is taking place; and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.

MDCH also has regular meetings with MDHS Licensing staff to identify issues of concern related to people living in licensed settings. Agendas and meeting notes are maintained.

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 CPS or APS, the appropriate agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the participant's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDCH contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

If an egregious event is reported through the Immediate Event Reporting or through other sources, MDCH may follow-up through a number of different approaches, including sending a site review nurse or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the PIHP, requiring additional training for PIHP providers, or other strategies as appropriate. During a QMP on-site visit, if the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

MDCH has a Virtual Team, where CMHSPs and PIHPs can request technical assistance by way of electronic secure communication for participants they are serving who may have experienced a critical event or are at risk of such. The Virtual Team consists of a group of professionals from a variety of disciplines, such as psychiatry, psychology, social work, occupational therapy, and housing and placement specialists. The Virtual Team can recommend the CMHSP or PIHP obtain consultants with expertise in addressing the participant's unique needs to develop strategies to prevent or minimize risk for incidents.

Another strategy MDCH may use to address immediate issues for a participant who has either experienced a critical incident or is a high risk of experiencing a critical incident is through its contract with the Center for Positive Living Supports. During the first year of operation in FY10, the services of the Center have primarily focused on the individuals who transitioned from the last ICF/MR in Michigan. All of those individuals are enrolled participants in the HSW. The Center offers several services that can address immediate crisis situations in an effort to prevent a critical incident from occurring or re-occurring. Services include 1) a 24-hour crisis line that is available for any authorized CMHSP representative, The Center clinician manning the Crisis Line will assist the CMHSP representative in identifying the environmental and relationship variables that may be influencing the crisis situation, and will attempt to provide clinical impressions and recommendations. If additional advice or consultations need to occur, the Center clinician will seek that assistance and call the CMHSP back within two hours. Should this consultation not resolve the crisis, the Center will request permission from MDCH for further support from the Center; 2) a Mobile Training/Crisis Team may be dispatched upon approval by MDCH and after all prerequisites have been met by the CMHSP, including training for its staff in culture of gentleness approaches. Within the first eight hours of service, the individual's care-givers will be asked to participate in the structure and interaction patterns established by the team. The team members will coach and mentor the individual's care-givers in this process. The manager and shift leader need to be the first staff working directly with the Mobile Team

and the individual. The team may remain on-site for up to two weeks, unless extended by authorization from MDCH; and 3) a Training and Crisis Transition Home - A CMHSP may request MDCH approval for the use of the Training and Crisis Transition Home once they have exhausted all local options of support and training and have utilized the services of the Center's Mobile Training/Crisis Team. Utilization of the Training and Crisis Transition Home will occur only after approval by MDCH and the Center.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the §1915(b) Managed Specialty Supports and Services waiver Control #MI-14.R05, Habilitation Support Waiver (HSW) Control #0167.90.R3, Children's Waiver Program (CWP) Control #4119.90.R3.01, and the Waiver for Children with Serious Emotional Disturbance (SEDW) Control #0438.R01.02. 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 MDCH QMP Site Review team conducts comprehensive biennial reviews at each of the 18 PIHPs (and affiliate CMHSPs). During the alternate years, QMP staff visit PIHP/CMHSPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of §1915(c) waiver participants are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews. In addition to identifying individual issues that are addressed in remediation, the QMP findings are also used for identifying trends to implement systems improvements. Clinical record reviews are completed to determine that: person-centered planning is utilized; health and welfare concerns are addressed if indicated; services identified in the plan of service are delivered in the amount, scope, duration and frequency specified in the IPOS; and delivery of service meets program requirements published in the Michigan Medicaid Provider Manual (MPM). The on-site reviews include a section specific to HSW quality management protocols to ensure that federal requirements and assurances of

quality are met. The MDCH QMP staff draws random samples of clinical records, including a proportionate random sample of the HSW population at each PIHP. Scope of reviews includes: Medicaid State Plan, §1915(b)(3) services, and HSW services; all affiliate CMHSPs (if applicable); a sample of providers; and a sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

The comprehensive administrative review is focused on policies, procedures, and initiatives that are not otherwise reviewed by the External Quality Review (EQR) and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH contract requirements including:
- PIHP/CMHSP Compliance with the MPM
- Written agreements with providers, community agencies
- The results of PIHP/CMHSP annual monitoring of its provider network
- Adherence to contractual practice guidelines
- Sentinel event management

Consumer/Stakeholder Meetings are completed during the biennial comprehensive review. The QMP staff meet with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered/family-centered planning, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the Quality Assessment and Performance Improvement Programs (QAPIP) and customer services; and the provider's responsiveness to the group's concerns and suggestions.

QMP staff conducts consumer interviews with a random sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with consumers who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the waivers.

A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDCH in 30 days. MDCH reviews and approves the plan of correction and evidence of remediation of issues is to be provided to MDCH by the PIHP within 90 days after approval of the plan. On-site follow-up is conducted the following year or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council (QIC), and HSW staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Michigan's QAPIP has been developed with the input of consumers and the Mental Health QIC that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Service Boards. Michigan's QAPIP is reviewed and revised with the §1915(b) waiver renewals and reflects the activities, concerns, input or recommendations from the Michigan Mental Health Commission, MDCH's Encounter Data Integrity Team (EDIT), MDCH's Administrative Simplification Process Improvement Team, EQR activities, and the terms and conditions from CMS' previous waiver approvals. The QMP Site Review Protocol is reviewed and revised to address changes in policy resulting from trends or system improvements.

The existing infrastructure in Michigan includes §1915(b) waiver authority to allow Michigan to provide mental health services not otherwise covered under the State Plan through a managed care delivery system. The concurrent §1915(b)/(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 MDCH/CMHSP contracts and they are reviewed by MDCH staff and/or the EQR process. While a review of the following three areas is not specific to the HSW, it assures overall quality services for all consumers.

EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes

and evidence that those policies and processes are being implemented. MDCH-BHDDA contracts with Health Services Advisory Group (HSAG) to conduct the EQR. The EQR consists of desk audits of PIHP documents, two-day 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 MDCH QMP on-site visit and/or the EQR address requirements for customer services: staff who are knowledgeable about referral systems to assist individuals in accessing services, a range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSPs network, performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP, focus of customer services is customer satisfaction and problem avoidance, assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications, and the relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Appeals and Grievances Mechanisms: The EQR reviews the process, information to recipients and contractors, method for filing, provision of assistance to consumers, process for handling grievances, record-keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Fair Hearings 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. MDCH also has regular meetings with the Administrative Tribunal to address trends and identify solutions.

Quality Assessment and Performance Improvement Programs: The MDCH contracts with PIHPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors the PIHP implementation of their local QAPIP plans that must include the required standards. QMP site reviews include review of implementation of standards for sentinel events and credentialing of providers. MDCH-BHDDA collects data for performance indicators and performance improvement projects.

In addition to the QMP strategies implemented for all consumers, the HSW program staff review all applications and monitor the timeliness of re-certifications by way of the web-based HSW database. The HSW program staff may participate in QMP site reviews of clinical and administrative records or provide technical consultation as requested by the Site Review Team during a PIHP/CMHSP review.

Trend patterns have been used to develop strategies for improvement. Data from site reviews, individual remediation and other sources have been used for systems improvement (SI) activities. In 2009, MDCH issued the Application for Renewal and Recommitment which lays out the Department's direction and vision for supports and services provided for all people served by the public mental health system (details can be found on the MDCH website). Creating a Culture of Gentleness (COG) is an SI activity aimed at helping providers understand that there are preferred alternative ways to work with individuals who have reputations for challenging behaviors, primarily by developing true relationships with them and helping them to feel safe, loved, be loving and be engaged. Regional intensive trainings are being provided for direct care workers, supervisors, and professional support staff who serve people with reputed challenging behaviors. MDCH also established a "safety net plan" to respond to PIHPs/CMHSPs that have exhausted their capacity to respond appropriately to people who exhibit behaviors that threaten their welfare or that of others. The plan builds on the intensive trainings by adding a mobile crisis response, and a temporary crisis placement. Information from the QMP site reviews, individual remediation, the COG initiative and safety net plan are used to inform the process for implementing further systems improvements toward reducing and/or eliminating restrictive interventions. Another statewide initiative focuses on prevention by developing parameters to help the PIHPs/CMHSPs identify people who may be vulnerable or at risk. By identifying people earlier, the PIHP/CMHSP can monitor closely and implement strategies to try to prevent critical incidents before they occur. Other examples of design changes resulting from the QI process include workshops for the Annual Statewide Waiver conference, identifying topics for technical assistance workshops at state and local levels, and providing training to HSW participants and their families.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

MDCH-BHDDA uses performance indicators to measure the performance of the PIHP/CMHSP on a number of domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management. Data colected for performance indicators can be identified at the individual HSW participant level if necessary.

Indicators are used to alert MDCH-BHDDA of systemic issues and PIHP/CMHSP-specific issues that need to be addressed immediately; to identify trends to watch; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and quality improvement (QI) data located in MDCH's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDCH and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action. Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH-MHSA management team, the QIC and HSW staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Participant level demographic data are reported monthly for each individual. Demographic data housed in the data warehouse is used for identifying the residential living arrangement for HSW participants, which is used in calculating the HSW capitation payment. A significant amount of work was done between MDCH-BHDDA HSW staff and the PIHPs to identify the process and challenges with demographic data used by the HSW for payment calculations. The process for assigning a residential living arrangement code was incorporated into the HSW web-based database, which must be in agreement with the demographic data submitted by the PIHP before enrolling a HSW participant. This process improvement has significantly increased the accuracy and timeliness of demographic data submissions for HSW participants in particular. Aggregate data from the encounter data system are shared with the MDCH-MHSA management team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

PIHPs are required by contract to submit Medicaid Utilization and Net Cost (MUNC) reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP and can be analyzed at the HSW participant level. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH-BHDDA management team, the EDIT, and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP for all HSW participants, as well as the following groups: beneficiaries receiving Targeted Case Management, participants enrolled in the CWP and the SEDW, and those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDCH semi-annually. Aggregate data are shared with MDCH-MHSA management team, the QIC and CWP staff. Information is used by MDCH to take contract action as needed, becomes the focus of on-site reviews conducted by MDCH, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP 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: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature. Data collection improvements distinguish Medicaid consumers from other individuals served. Information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDCH-MHSA management team, the QIC, and HSW staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

CMHSPs are required to submit to MDCH information about each of their Medicaid service providers at least every three years with interim updates as necessary (e.g., changes/additions of new providers: termination of contracts, change in accreditation status, change of address). This information is kept in a database and is used by the MDCH-BHDDA to verify the capacity of the service network. All of the PIHPs are comprised of one (stand-alone) or more (affiliation) CMHSPs.

The EQR process checks for PIHP policy and processes and evidence that those policies and processes are being implemented. Although the data is not necessarily specific to the HSW, because HSW participants represent a significant percentage of the Medicaid beneficiaries who have developmental disabilities, the findings of PIHP performance are considered a valid data source for assuring the PIHP policies and procedures in the 13 areas are met. This data source is also used to identify areas for system design change and improvements.

The MDCH-BHDDA staff collaborates with the Quality Improvement Council to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and stakeholder concerns. Michigan requires all PIHP/CMHSPs to conduct a minimum of two performance improvement projects. All PIHP/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDCH; in the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide. All PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHP/CMHSPs choose their second performance improvement project.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDCH performance improvement project reports are shared with MDCH-BHDDA management team, the QIC and HSW staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDCH-BHDDA staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the QMP on-site reviews and the EQRs are shared with MDCH-BHDDA management team and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

The Application for Renewal and Recommitment (ARR) brings the PIHPs, CMHSPs, individuals receiving services, their supporters and other partners to work toward improving statewide equity of service opportunity and quality of service outcomes so people are provided options that best fit their preferences and help them achieve true community membership. Each PIHP was required to respond to this quality improvement effort to address 11 topics: partnering with stakeholders in design, delivery and evaluation;

improving the culture of systems of care; assuring active engagement; supporting maximum consumer choice and control; expanding opportunity for integrated employment; treatment for people in the criminal justice system; assessing needs and managing demand; coordinating and managing care; improving the quality of supports and services; developing and maintaining a competent workforce; and achieving administrative efficiencies. PIHPs completed environmental scans and submitted plans for improvement with specific benchmarks and timeframes for achieving their plans. MDCH-BHDDA staff are assigned to ARR teams and are working closely with PIHPs, CMHSPs, and stakeholders on their ARR activities. MDCH is curently evaluating individual progress reports submitted by the PIHPs to update the first year's work and is utizling the results of the PIHP responses to target technical assistance and to facilitate the sharing of successful methods and practices. This is a multi-year developmental effort that is expected to continue through the waiver renewal period.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIC would address QI strategies and systems improvements required for the HSW, as well as all the waiver populations served by Michigan's mental health system. To the extent that the MDCH-BHDDA/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next §1915(b) waiver renewal.

The MDCH-BHDDA leadership meets regularly with the PIHP and CMHSP directors and quality improvement strategies may be discussed during the course of those meetings. Feedback from the group is used to help evaluate the QI process and identify opportunities for improvements to MDCH-BHDDA management team and the QIC.

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.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Habilitation Supports Waiver operates concurrently with the State's §1915(b) waiver. The §1915(b) financial accountability requirements apply. The HSW capitation payments are made to the PIHPs for the delivery of waiver services and PIHPs in turn, pays within [and when requested, outside] their networks of contracted providers. There are no fee-for-service payments for waiver services.

a) The MDCH/PIHP concurrent §1915(b)/(c) contract includes requirements for PIHPs to complete independent audits.

b) Pursuant to the MDCH/PIHP and MDCH/CMHSP contracts, PIHPs and CMHSPs must submit to MDCH 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 MDCH/PIHP and MDCH/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 MDCH to manage the concurrent §1915(b)/(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 MDCH the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDCH-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end.

PIHPs/CMHSPs are obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the State's BBA-compliant Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: whether services claimed were listed in the Michigan Medicaid Provider Manual; whether services were identified in the person-centered plan; and verification of documentation that services claimed were actually provided. Sampling methodologies are used to conduct the Medicaid services verification reviews, which cover all Medicaid-reimbursed services. A report, known as the “Medicaid Services Verification Report", is submitted to and reviewed by MDCH's Division of QMP annually. Although the report does not specifically look at HSW services, because HSW enrollees represent a sizable proportion of people served who have developmental disabilities, the report is used to note overall trends.

In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend $500,000 or more in federal awards during their fiscal year must submit to MDCH a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.

Capitation payments for the delivery of HSW services are issued by the Medicaid agency through the new online Medicaid claims processing system [Community Health Automated Medicaid Processing System (CHAMPS)], which replaced the old Medicaid Management Information System (MMIS) claims processing system. This web-based system is used to process and pay capitation payments, e.g., monthly prepayments made on behalf of the beneficiaries of the §1915(b)/(c) concurrent waivers, and all Medicaid fee-for-service claims. System requirements to enable processing of waiver capitation payments through CHAMPS have been incorporated into all aspects of design for this system. Significant work has been devoted to the CHAMPS/HSW interface to assure payments are only made to a PIHP for eligible participants who are properly enrolled in the HSW. The HSW web-based database is the system of record for maintaining enrollment information. Each month, an interface file is transmitted from the HSW database to the CHAMPS system for processing. Before an HSW capitation payment is issued for a participant enrolled in the waiver, various parameters must be met, including the participant having active Medicaid eligibility. The interface from HSW database establishes an “eligibility segment” meaning that the member meets all the requirements of enrollment into the waiver. Then CHAMPS requires that the HSW benefit plan be opened. The HSW benefit plan will only open once the member has obtained full Medicaid. A series of edits are in place to assure payments are only issued for participants who are eligible to receive the payment and that the payment is the correct rate based on factors determined by the actuary and approved by CMS. CHAMPS produces HIPAA-compliant 834 and 820 reports to the PIHPs to identify HSW participants in the enrollment file and that received a capitation payment for the month. Because capitation payments are issued prospectively, the CHAMPS system will have the capability to recover HSW payments retroactively if there is no HSW encounter in the data warehouse to substantiate that the HSW participant received at least one HSW service during the month. Until the CHAMPS system automates this process, the recoupment process is completed manually.

c) The PIHPs are responsible for having independent audits completed as noted above. At the state level, the MDCH Office of Audit and the MDCH-BHDDA Bureau of Community Mental Health Services review the reports, issue management decisions, and follow-up as needed.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
    i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of capitation payments made to the PIHP only for HSW participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHP for HSW participants with active Medicaid eligibility. Denominator: All capitation payments for HSW participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CHAMPS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of HSW participants whose capitation payment was recouped for a service month d/t not receiving an HSW service (i.e., no valid encounter in the data warehouse). Numerator: Number of HSW participants whose capitation payment was recouped for a service month due to no valid encounter. Denominator: All HSW participants with no valid encounter for a service month.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CHAMPS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The QMP Site Review includes an examination of the participant's IPOS and the supporting documentation that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.
Because this is a capitation payment system based upon encounters, payments are processed on a monthly basis with a rolling quarter look-back. If individual payment issues are noted by the PIHP, it contacts MDCH to investigate and correct the payment if applicable. This process generally is completed within one payment month.

MDCH Office of Audit reviews the Financial Statement Audit and Compliance Examination Reports. When irregularities are found, the PIHP must submit a Corrective Action Plan. The MDCH Office of Audit or MDCH-BHDDA Bureau of Community Mental Health issues a management decision regarding whether the corrective action plan is sufficient to address the issues. If the plan is not sufficient to correct the issue, it would be addressed in the management decision letter as to why the corrective action plan is not sufficient and what further corrective action is required. Follow-up by MDCH requires the PIHP to report on the current status toward correction and implementation of the plan. In addition to this process, the MDCH-BHDDA Division of Program Development, Consultation, and Contracts may provide technical assistance to PIHPs to help in correcting financial irregularities and assuring fiscal integrity in accordance with OMB Circular A-87.

The PIHP/CMHSP and other qualified/approved community-based mental health and developmental disability services providers monitor claims through the services verification review process described above. A final report is prepared which details findings and discrepancies with financial implications, and corrective action taken or to be taken. In those instances where a recommendation is made regarding internal procedures, PIHP/CMHSP staff follows up with the provider on actions taken to correct and monitor identified deficiencies. If an identified problem rises to a level of fraud and abuse, the PIHP/CMHSP is required to report the finding to the MDCH Medicaid Fraud Unit for investigation and follow-up. If it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

If the QMP site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by MDCH-BHDDA.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 §1915(b) waiver. Please refer to the Michigan's approved §1915(b) Managed Specialty Service and Supports waiver application and associated materials.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The PIHP contracted providers submit HSW services encounters/claims to the PIHPs; the clean claims are then adjudicated and paid [out of the PIHP's capitation funds] within the payment timeliness parameters specified in their PIHP contracts; the definition of clean claim, the flow of billings, and the payment timeliness parameters, etc. are governed by the MDCH/PIHP contract requirements at Section 6.6.3.

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 asure that the CPE is based on total computable costs for the concurrent b/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. MDCH reviews the annual compliance exam to assure that any irregularities are addressed by the PIHP.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The quarterly CMS 64 Claims for federal financial participation for this waiver program are made based on the monthly §1915(c) waiver capitation payments made to the PIHPs on behalf of the participants enrolled in this waiver program.

a) These capitation payments are made only after the each participant'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 HSW participants is reviewed to assure that capitation payments are made only for HSW participants with active Medicaid eligibility.

b) The QMP Site Review Team reviews a proportionate random sample of HSW participants during each comprehensive full review. This review includes an examination of the participant's IPOS and the supporting documentation (e.g., progress notes, time sheets, claims from providers to the PIHP, or any other relevant evidence) that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS. This is reflected in a performance measure in the QIS for Appendix D.

c) MDCH recovers from the PIHP any capitation payments made for participants for any month they did not, upon retrospective review of their encounter data, also receive at least one waiver service in the month. Any such deduction will be reflected in the CMS 64 for the payment period. Per the performance measure in the QIS for this appendix, a representative random sample of all HSW participants is reviewed to assure that capitation payments are recouped for a service month where an HSW participant did not receive at least one HSW service.

Section 6.6.3 of the MDCH/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 participants.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

  As noted in I-1, the HSW database is the system of record for enrollment into the waiver. On a monthly basis, enrollment data and associated payment elements, such as the residential living arrangement, are interfaced from the HSW database to CHAMPS. If the HSW participant is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the HSW benefit plan is opened. If the HSW participant is non-Medicaid eligible, notification is sent back to the HSW database advising that a particular record did not process for payment and must be resubmitted next cycle. If the HSW benefit plan is open, the PIHP receives an electronic member file (834) containing HSW enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the HSW participant has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the HSW capitation payments are made by MDCH to the PIHPs' accounts and a payment record (820) is issued to the PIHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

not applicable

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

PIHPs are the lead CMHSPs, which are local governmental entities. The PIHPs receive capitation payments and furnish, either directly or through contracts with networks of qualified providers, the full array of this waiver's services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

The MDCH/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 §1915(b)/(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 MDCH/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 §1915(b)/(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ( ) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- (●) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **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 MDCH/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 MDCH 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 MDCH Contract with the PIHPs. The PIHPs pay for HSW services. The other costs of the subcontractor residential provider, including room and board, can only be paid by using SSI or state general fund dollars.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	47352.81	18508.00	65860.81	307110.00	2540.00	309650.00	243789.19
2	49728.37	18098.00	67826.37	345714.00	2508.00	348222.00	280395.63
3	51991.50	17698.00	69689.50	389171.00	2477.00	391648.00	321958.50
4	54504.11	17306.00	71810.11	438091.00	2446.00	440537.00	368726.89
5	57287.00	16923.00	74210.00	493160.00	2416.00	495576.00	421366.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	8268	8268	
Year 2	8268	8268	
Year 3	8268	8268	
Year 4	8268	8268	
Year 5	8268	8268	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Average Length of Stay was estimated using the State's attrition replacement enrollment management plan, wherein the State fills in behind each participant who leaves the waiver in the month immediately following their leaving/termination from the waiver, thereby maintaining the enrollment at or near the level supported by the legislative appropriation.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimates of Factor D at the service detail level are based on MMIS/CHAMPS data equivalent to the information previously required on the CMS 372 long form for §1915(c) Habilitation Supports Waiver and trended forward using the average rate of change for a service where the State had sufficient experience and data upon which to base the projection. The service level detail expenditures were totaled and divided by the unduplicated count of the Waiver beneficiaries who used and/or received them. The waiver template does not currently permit the State to derive Factor D from capitation payment history. If, at some future date, the template is revised to enable the State to derive Factor D using capitation payments instead of service level detail, the State can supply CMS with those figures.

For the new service, Goods and Services, the number of users was estimated to be 5% of the total self-directed participants denoted in Appendix E-1-n, with a projected increase of 1.25% per year. The base cost of $300.00 was derived from estimates from the MI Choice Waiver (Control #MI.0233) program and trended forward using the aggregate services costs rate of change.

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:

Estimates of Factor D' are based on MMIS/CHAMPS data equivalent to the information previously required on the CMS 372 long form, i.e. Medicaid cost (fee-for-service, HMO managed care capitation payments, etc.) for all other services provided to individuals in the waiver program divided by the unduplicated count of the Waiver beneficiaries who used and/or received them, and trended forward using the average rate of change for the prior three year period. The base years' Prescribed Drug expenditures used in the projection of D' were those made on behalf of Medicaid-only waiver enrollees; that is, the costs of prescribed drugs for dual eligible individuals covered by Medicare Part D effective 1/1/06 were not included in the D' projection calculations.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G are based on MMIS data equivalent to the information previously required for Cost Effectiveness formula Factor B on the 372 long form, i.e. total [nonwaiver] ICF/MR expenditures divided by the unduplicated count of [nonwaiver] ICF/IID beneficiaries, and trended forward.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates of Factor G' are based on MMIS data equivalent to the information previously required for Cost Effectiveness formula Factor B' on the 372 long form using fiscal years 2005-2008, that is, the Medicaid expenditures for all services other than those included in Factor B (ICF/IID services) provided to [non-waiver] beneficiaries, divided by the unduplicated count of the [non-waiver] ICF/IID beneficiaries who used/received them, and trended forward.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Out-of-Home Non-Vocational Habilitation	
Prevocational Services	
Respite	
Supported Employment	
Supports Coordination	
Enhanced Medical Equipment and Supplies	
Enhanced Pharmacy	
Goods and Services	
Community Living Supports	
Environmental Modifications	
Family Training	
Personal Emergency Response System	
Private Duty Nursing	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**50333967.20**
Out-of-Home Non-Vocational Habilitation	✓	15 minutes	4015	2992.00	4.19	**50333967.20**	
Prevocational Services Total:							**13475363.22**
Prevocational Services	✓	Hour	971	774.00	17.93	**13475363.22**	
Respite Total:							**2711610.54**
Respite, out-of -home setting	✓	Day	101	15.00	231.25	**350343.75**	
Respite, in-home setting	✓	Day	69	23.00	77.57	**123103.59**	
Respite, 15 minutes	✓	15 minutes	427	1248.00	4.20	**2238163.20**	
Supported Employment Total:							**7129971.75**
Supported Employment	✓	15 minutes	985	1177.00	6.15	**7129971.75**	
Supports Coordination Total:							**26842668.84**
Supports Coordination	✓	15 minutes	8229	36.00	90.61	**26842668.84**	
Enhanced Medical Equipment and Supplies Total:							**1704698.24**
Enhanced Medical Equipment and Supplies	✓	Item	931	8.00	228.88	**1704698.24**	
Enhanced Pharmacy Total:							**251219.07**
Enhanced Pharmacy	✓	Item	937	9.00	29.79	**251219.07**	
Goods and Services Total:							**201600.00**
Goods and Services	✓	Item	56	12.00	300.00	**201600.00**	
Community Living Supports Total:							**282356589.60**
CLS per 15 minutes	✓	15 minutes	2798	5646.00	4.20	**66349533.60**	

GRAND TOTAL:	**391513066.30**
Total: Services included in capitation:	391513066.30
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**47352.81**
Services included in capitation:	47352.81
Services not included in capitation:	
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CLS per diem	✓	Day	6245	288.00	120.10	216007056.00	
Environmental Modifications Total:							358649.64
Environmental Modifications	✓	Service	54	2.00	3320.83	358649.64	
Family Training Total:							43223.04
Family Training	✓	Session	84	4.00	128.64	43223.04	
Personal Emergency Response System Total:							1445727.88
PERS installation & testing	✓	Service	44	1.00	749.27	32967.88	
PERS monthly monitoring	✓	Month	193	12.00	610.00	1412760.00	
Private Duty Nursing Total:							4657777.28
PDN by RN	✓	Hour	12	966.00	42.70	494978.40	
PDN by LPN	✓	Hour	23	2332.00	36.52	1958786.72	
PDN by RN or LPN, per 15 min	✓	15 minutes	28	8208.00	9.59	2204012.16	

GRAND TOTAL:	**391513066.30**
Total: Services included in capitation:	391513066.30
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**47352.81**
Services included in capitation:	47352.81
Services not included in capitation:	
Average Length of Stay on the Waiver:	356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**52616414.40**
Out-of-Home Non-Vocational Habilitation	✓	15 minutes	4015	2992.00	4.38	**52616414.40**	
Prevocational Services Total:							**13881202.38**
Prevocational Services	✓	Hour	971	774.00	18.47	**13881202.38**	
Respite Total:							**2760202.74**
Respite, out-of -home setting	✓	Day	101	15.00	255.24	**386688.60**	
Respite, in-home setting	✓	Day	69	23.00	65.14	**103377.18**	
Respite, 15 minutes	✓	15 minutes	427	1248.00	4.26	**2270136.96**	
Supported Employment Total:							**7396621.10**
Supported Employment	✓	15 minutes	985	1177.00	6.38	**7396621.10**	
Supports Coordination Total:							**28978588.08**
Supports Coordination	✓	15 minute	8229	36.00	97.82	**28978588.08**	
Enhanced Medical Equipment and Supplies Total:							**1750801.36**
Enhanced Medical Equipment and Supplies	✓	Item	931	8.00	235.07	**1750801.36**	
Enhanced Pharmacy Total:							**264205.89**
Enhanced Pharmacy	✓	Item	937	9.00	31.33	**264205.89**	
Goods and Services Total:							**209751.36**
Goods and Services	✓	Item	56	12.00	312.13	**209751.36**	
Community Living Supports Total:							**296477112.24**
CLS per 15 minutes	✓	15 minutes	2798	5646.00	4.38	**69193085.04**	

GRAND TOTAL:	**411154142.19**
Total: Services included in capitation:	411154142.19
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**49728.37**
Services included in capitation:	49728.37
Services not included in capitation:	
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CLS per diem	✓	Day	6245	288.00	126.37	227284027.20	
Environmental Modifications Total:							376029.00
Environmental Modifications	✓	Item	54	2.00	3481.75	376029.00	
Family Training Total:							44039.52
Family Training	✓	Session	84	4.00	131.07	44039.52	
Personal Emergency Response System Total:							1512491.56
PERS installation & testing	✓	Month	44	1.00	783.86	34489.84	
PERS monthly monitoring	✓	Month	193	12.00	638.17	1478001.72	
Private Duty Nursing Total:							4886682.56
PDN by RN	✓	Hour	12	966.00	44.80	519321.60	
PDN by LPN	✓	Hour	23	2332.00	38.32	2055331.52	
PDN by RN or LPN, per 15 min	✓	15 minutes	28	8208.00	10.06	2312029.44	

GRAND TOTAL:	**411154142.19**
Total: Services included in capitation:	411154142.19
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**49728.37**
Services included in capitation:	49728.37
Services not included in capitation:	
Average Length of Stay on the Waiver:	356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**54898861.60**
Out-of-Home Non-Vocational Habilitation	✓	15 minutes	4015	2992.00	4.57	**54898861.60**	
Prevocational Services Total:							**14302072.62**
Prevocational Services	✓	Hour	971	774.00	19.03	**14302072.62**	
Respite Total:							**2821070.25**
Respite, out-of -home setting	✓	Day	101	15.00	281.72	**426805.80**	
Respite, in-home setting	✓	Day	69	23.00	54.71	**86824.77**	
Respite, 15 minutes	✓	15 minutes	427	1248.00	4.33	**2307439.68**	
Supported Employment Total:							**7674863.90**
Supported Employment	✓	15 minutes	985	1177.00	6.62	**7674863.90**	
Supports Coordination Total:							**29393329.68**
Supports Coordination	✓	15 minutes	8229	36.00	99.22	**29393329.68**	
Enhanced Medical Equipment and Supplies Total:							**1798170.64**
Enhanced Medical Equipment and Supplies	✓	Item	931	8.00	241.43	**1798170.64**	
Enhanced Pharmacy Total:							**277951.68**
Enhanced Pharmacy	✓	Item	937	9.00	32.96	**277951.68**	
Goods and Services Total:							**218232.00**
Goods and Services	✓	Item	56	12.00	324.75	**218232.00**	
Community Living Supports Total:							**311331149.16**
CLS per 15 minutes	✓	15 minutes	2798	5646.00	4.57	**72194611.56**	

GRAND TOTAL:	**429865718.85**
Total: Services included in capitation:	429865718.85
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**51991.50**
Services included in capitation:	51991.50
Services not included in capitation:	
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CLS per diem	✓	Day	6245	288.00	132.96	239136537.60	
Environmental Modifications Total:							394249.68
Environmental Modifications	✓	Service	54	2.00	3650.46	394249.68	
Family Training Total:							44869.44
Family Training	✓	Session	84	4.00	133.54	44869.44	
Personal Emergency Response System Total:							1582313.28
PERS installation & testing	✓	Service	44	1.00	820.05	36082.20	
PERS monthly monitoring	✓	Month	193	12.00	667.63	1546231.08	
Private Duty Nursing Total:							5128584.92
PDN by RN	✓	Hour	12	966.00	47.01	544939.92	
PDN by LPN	✓	Hour	23	2332.00	40.21	2156703.56	
PDN by RN or LPN, per 15 min	✓	15 minutes	28	8208.00	10.56	2426941.44	

GRAND TOTAL:	**429865718.85**
Total: Services included in capitation:	429865718.85
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**51991.50**
Services included in capitation:	51991.50
Services not included in capitation:	
Average Length of Stay on the Waiver:	350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**57421566.40**
Out-of-Home Non-Vocational Habilitation	✓	15 minutes	4015	2992.00	4.78	**57421566.40**	
Prevocational Services Total:							**14730458.40**
Prevocational Services	✓	Hour	971	774.00	19.60	**14730458.40**	
Respite Total:							**2888738.43**
Respite, out-of -home setting	✓	Day	101	15.00	310.95	**471089.25**	
Respite, in-home setting	✓	Day	69	23.00	45.94	**72906.78**	
Respite, 15 minutes	✓	15 minutes	427	1248.00	4.40	**2344742.40**	
Supported Employment Total:							**7953106.70**
Supported Employment	✓	15 minutes	985	1177.00	6.86	**7953106.70**	
Supports Coordination Total:							**30759014.52**
Supports Coordination	✓	15 minutes	8229	36.00	103.83	**30759014.52**	
Enhanced Medical Equipment and Supplies Total:							**1846806.08**
Enhanced Medical Equipment and Supplies	✓	Item	931	8.00	247.96	**1846806.08**	
Enhanced Pharmacy Total:							**292287.78**
Enhanced Pharmacy	✓	Item	937	9.00	34.66	**292287.78**	
Goods and Services Total:							**279756.36**
Goods and Services	✓	Item	69	12.00	337.87	**279756.36**	
Community Living Supports Total:							**326972657.16**
CLS per 15 minutes	✓	15 minutes	2798	5646.00	4.77	**75354113.16**	

GRAND TOTAL:	**450640007.23**
Total: Services included in capitation:	450640007.23
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**54504.11**
Services included in capitation:	54504.11
Services not included in capitation:	
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CLS per diem	✓	Day	6245	288.00	139.90	**251618544.00**	
Environmental Modifications Total:							**413354.88**
Environmental Modifications	✓	Service	54	2.00	3827.36	**413354.88**	
Family Training Total:							**45716.16**
Family Training	✓	Session	84	4.00	136.06	**45716.16**	
Personal Emergency Response System Total:							**1655358.24**
PERS installation & testing	✓	Service	44	1.00	857.91	**37748.04**	
PERS monthly monitoring	✓	Month	193	12.00	698.45	**1617610.20**	
Private Duty Nursing Total:							**5381186.12**
PDN by RN	✓	Hour	12	966.00	49.33	**571833.36**	
PDN by LPN	✓	Hour	23	2332.00	42.19	**2262902.84**	
PDN by RN or LPN, per 15 min	✓	15 minutes	28	8208.00	11.08	**2546449.92**	

GRAND TOTAL:	**450640007.23**
Total: Services included in capitation:	450640007.23
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**54504.11**
Services included in capitation:	54504.11
Services not included in capitation:	
Average Length of Stay on the Waiver:	350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**59944271.20**
Out-of-Home Non-Vocational Habilitation	✓	15 minutes	4015	2992.00	4.99	**59944271.20**	
Prevocational Services Total:							**15181390.80**
Prevocational Services	✓	Hour	971	774.00	20.20	**15181390.80**	
Respite Total:							**2957905.77**
Respite, out-of -home setting	✓	Day	101	15.00	343.21	**519963.15**	
Respite, in-home setting	✓	Day	69	23.00	38.58	**61226.46**	
Respite, 15 minutes	✓	15 minutes	427	1248.00	4.46	**2376716.16**	
Supported Employment Total:							**8242942.95**
Supported Employment	✓	15 minutes	985	1177.00	7.11	**8242942.95**	
Supports Coordination Total:							**32189873.04**
Supports Coordination	✓	15 minutes	8229	36.00	108.66	**32189873.04**	
Enhanced Medical Equipment and Supplies Total:							**1896782.16**
Enhanced Medical Equipment and Supplies	✓	Item	931	8.00	254.67	**1896782.16**	
Enhanced Pharmacy Total:							**307467.18**
Enhanced Pharmacy	✓	Item	937	9.00	36.46	**307467.18**	
Goods and Services Total:							**1633911.44**
Goods and Services	✓	Item	56	83.00	351.53	**1633911.44**	
Community Living Supports Total:							**343437607.44**
CLS per 15 minutes	✓	15 minutes	2798	5646.00	4.98	**78671589.84**	

GRAND TOTAL:	**473648903.86**
Total: Services included in capitation:	473648903.86
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**57287.00**
Services included in capitation:	57287.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CLS per diem	✓	Day	6245	288.00	147.21	**264766017.60**	
Environmental Modifications Total:							**433384.56**
Environmental Modifications	✓	Service	54	2.00	4012.82	**433384.56**	
Family Training Total:							**46576.32**
Family Training	✓	Session	84	4.00	138.62	**46576.32**	
Personal Emergency Response System Total:							**1731768.48**
PERS installation & testing	✓	Service	44	1.00	897.51	**39490.44**	
PERS monthly monitoring	✓	Month	193	12.00	730.69	**1692278.04**	
Private Duty Nursing Total:							**5645022.52**
PDN by RN	✓	Hour	12	966.00	51.76	**600001.92**	
PDN by LPN	✓	Hour	23	2332.00	44.27	**2374465.72**	
PDN by RN or LPN, per 15 min	✓	15 minutes	28	8208.00	11.62	**2670554.88**	

GRAND TOTAL:	**473648903.86**
Total: Services included in capitation:	473648903.86
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**8268**
Factor D (Divide total by number of participants):	**57287.00**
Services included in capitation:	57287.00
Services not included in capitation:	
Average Length of Stay on the Waiver:	350