



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

April 2010

<NAME>
<TITLE>
<ADDRESS>
<ADDRESS>
<CITY> <STATE> <ZIP CODE>

Dear Tribal Chair and Health Director:

RE: Notice of Intent to Submit the Children’s Waiver Program Section 1915(c) Renewal Application

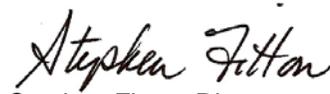
The Michigan Department of Community Health (MDCH) is notifying you of its intent to submit the Section 1915(c) renewal application for the Home and Community-Based Services Waiver for Developmentally Disabled Children, known as the Children’s Waiver Program (CWP) to the Centers for Medicare and Medicaid Services (CMS). If approved, this waiver will allow the State to continue to provide Medicaid funded home and community-based services to children under the age of 18 who have developmental disabilities and who are eligible for, and at risk of, placement into an Intermediate Care Facility for the Mentally Retarded. Services are provided through local Community Mental Health Service Programs, and their contracted agencies.

The enclosed document is the CWP Waiver Application for 2005-2010 (last amended effective October 1, 2008) as approved by CMS. The waiver is also available on the MDCH website at www.michigan.gov/medicaidproviders >> Waivers. Two additional waiver services will be requested in this renewal application. One service - “Family Support and Training” - is a family-focused service provided by a peer-parent who has completed specialized training. The other service – “Fiscal Intermediary Services” – is a service that handles the financial flow-through of Medicaid dollars for children using Choice Voucher arrangements. In addition, provider qualifications for current services will be updated as necessary to align with changes in licensing and certification. (Current services are defined in Appendix B-1 of the enclosed waiver application, and provider qualifications are detailed in Appendix B-2.) Headings to each of the areas affected have been highlighted for easy identification. All other essential features of the waiver will remain as currently approved.

You may submit comments regarding this renewal application to msapolicy@michigan.gov. If you would like to discuss the renewal application, please contact Mary Anne Tribble, Medicaid Liaison to the Michigan Tribes. Mary Anne can be reached at (517) 241-7185 or via e-mail at tribblema@michigan.gov.

There is no public hearing scheduled for this waiver renewal application.

Sincerely,


Stephen Fitton, Director
Medical Services Administration

cc: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Sharon Teeple, Inter-Tribal Council of Michigan
Mary Anne Tribble, MDCH

Enclosure

Numbered Letter L 10-16 - Distribution

Mr. Jeffrey D Parker, President, Bay Mills Indian Community
Mr. Derek J Bailey, Tribal Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Mr. W Chris Swartz, President, Keweenaw Bay Indian Community
Mr. Jim Williams, Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. DK Sprague, Tribal Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Mr. Ken Harrington, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Mr. Homer Mandoka, Vice Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Mr. Matt Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Dennis V Kequom Sr, Tribal Chief, Saginaw Chippewa Indian Tribe
Mr. Darwin McCoy, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Ms. Laurel Keenan, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Vacant, Health Director, Grand Traverse Band Ottawa/Chippewa
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Jon Gardner, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Ms. Terry Fox, Health Director, Lac Vieux Desert Band
Ms. Phyllis Davis, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Janice Grant, Health Director, Little River Band of Ottawa Indians
Ms. Sharon Sierzputowski, Health Director, Little Traverse Bay Band of Odawa
Ms. Gail George, Health Director, Nimkee Memorial Wellness Center
Mr. Arthur Culpepper, Health Director, Pokagon Potawatomi Health Services
Ms. Bonnie Culfa, Health Director, Sault Ste. Marie HHS

cc:

Ms. Sharon Teeple, Executive Director, Inter-Tribal Council of Michigan
Mr. Rick Haverkate, Health Service Director, Inter-Tribal Council of Michigan, Inc.
Ms. Jerilyn Church, Director, Detroit American Indian Health Center
Ms. Pamela Carson, , Centers for Medicare and Medicaid Services
Dr. Kathleen Annette, MD, Area Director, Indian Health Service - Bemidji Area Office

HOME AND COMMUNITY-BASED SERVICES WAIVER APPLICATION

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SECTION 1915(c) WAIVER FORMAT

1. The State of Michigan requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. _____ Yes b. xx _____ No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. _____ 3 years (initial waiver)

b. xx _____ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. _____ Nursing facility (NF)

b. xx _____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

c. _____ Hospital

d. _____ NF (served in hospital)

e. _____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. _____ aged (age 65 and older)

b. _____ disabled

c. _____ aged and disabled

d. _____ mentally retarded

e. xx _____ developmentally disabled

- f. _____ mentally retarded and developmentally disabled
 - g. _____ chronically mentally ill
4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):
- a. xx _____ Waiver services are limited to the following age groups (specify):

Under the age of 18
 - b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
 - c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
 - d. xx _____ Other criteria. (Specify): Resides with his/her birth /adoptive parent(s); or in a specialized foster care home (with a Permanency plan to return home within one month); or in a relative's home, provided that the relative has been named the legal guardian for that child under the laws of the State of Michigan and is not a paid foster parent for that child.
 - e. _____ Not applicable.
5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

- a. xx Yes
- b. _____ No

7. A waiver of '1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

- a. xx Yes
- b. _____ No
- c. _____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

- a. _____ Yes
- b. xx No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

- a. _____ Yes
- b. xx No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

- a. _____ Case management
- b. _____ Homemaker
- c. _____ Home health aide services
- d. _____ Personal care services
- e. xx Respite care
- f. _____ Adult day health

- g. _____ Habilitation
 - _____ Residential habilitation
 - _____ Day habilitation
 - _____ Prevocational services
 - _____ Supported employment services
 - _____ Educational services
- h. xx _____ Environmental accessibility adaptations
- i. _____ Skilled nursing
- j. xx _____ Transportation
- k. xx _____ Specialized medical equipment and supplies
- l. _____ Chore services
- m. _____ Personal Emergency Response Systems
- n. _____ Companion services
- o. _____ Private duty nursing
- p. xx _____ Family training
- q. _____ Attendant care
- r. _____ Adult Residential Care
 - _____ Adult foster care
 - _____ Assisted living

s. _____ Extended State plan services (Check all that apply):

- _____ Physician services
- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other (specify):

t. xx _____ Other services (specify):

- Non-Family Training
- Specialty Services
- Community Living Supports

u. _____ The following services will be provided to individuals with chronic mental illness:

- _____ Day treatment/Partial hospitalization
- _____ Psychosocial rehabilitation
- _____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services

furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. xx When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. _____ Meals furnished as part of a program of adult day health services.

c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3

and 4 of this request, the individual or his or her legal representative will be:

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

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be

consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. xx Yes b. _____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. _____ Yes b. xx No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further

assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of October 1,2005 is requested.

20. The State contact person for this request is Deborah Milhouse-Slaine, who can be reached by telephone at (517)241-5757.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: **(Note: signature on file with the waiver application submitted 6/30/2005)**

Print Name: Paul Reinhart

Title: Director of Medical Services Administration

Date: 6/30/2005

APPENDIX A - ADMINISTRATION OF THE WAIVER

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

xx _____ The waiver will be operated by Michigan Department of Community Health (MDCH), the Single State agency. The Medicaid agency, MDCH, exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. MDCH contracts with the CMHSPs as a "local non-state public agency" to conduct operational and administrative functions at the local level. There is an agreement between MDCH and the CMHSPs that sets forth the responsibilities and performance requirements. MDCH is responsible for assessing the performance of CMHSPs. The assessment methods and frequency is fully detailed in Appendix H.

c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

_____ As indicated in the plan of care

_____ Other (Specify):

4. Relationship to State plan services (Check one):

_____ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with

limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. xx Respite care:

xx Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

_____ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

xx Individual's home or place of residence

xx Foster home

_____ Medicaid certified Hospital

_____ Medicaid certified NF

_____ Medicaid certified ICF/MR

xx Group home

xx Licensed respite care facility

_____ Other community care residential facility approved by the State that is not a private residence (Specify type):

xx Other service definition (Specify):

____ Habilitation assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

_____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services

may serve to reinforce skills or lessons taught in school, therapy, or other settings.

_____ Prevocational services 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)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

_____ Individuals will not be compensated for prevocational services.

_____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. 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 individuals 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.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

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

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives

_____ Other service definition (Specify):

i. _____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. xx _____ Transportation:

xx _____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. For purposes of this waiver, transportation is subject to what is reasonable and cost-effective, and limited to local destinations. "Local" is defined as destinations within the child's county of residence or a bordering county.

_____ Other service definition (Specify):

k. xx _____ Specialized Medical Equipment and Supplies:

xx _____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

_____ Other service definition (Specify):

1. _____ Chore services:

_____ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

m. _____ Personal Emergency Response Systems (PERS)

_____ PERS is an electronic device which 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 person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS

services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

n. _____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

o. _____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify):

p. xx Family training

xx Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent and/or siblings. "Family" does not include

individuals who are employed to care for the consumer. 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 individual at home.

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

_____ Other service definition (Specify):

q. _____ Attendant care services:

Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered

nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements

_____ Other service definition (Specify):

r. _____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed _____). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care

directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.)

Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- _____ Home health care
- _____ Physical therapy
- _____ Occupational therapy
- _____ Speech
- _____ Medication administration

- _____ Intermittent skilled nursing services
- _____ Transportation specified in the plan of care
- _____ Periodic nursing evaluations
- _____ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

_____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. xx Other waiver services that are cost-effective and necessary to prevent institutionalization (Specify):

Non-Family Training: This service provides coaching, supervision and monitoring services of hourly care staff by professional staff (LLP, MSW, or QMRP) to implement the Plan of Supports and Service (POS) that addresses services designed to improve the child=s social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

Specialty Services: This is an alternative service that can be used in lieu of or in combination with traditional professional services. The focus of specialty services is to interact with the child, family and staff to accomplish the goals identified in the Plan of Supports and Services (POS) in addition to using the traditional professional therapy model included in the state plan coverages. The POS ensures

the child=s health, safety and skill development and maintains the child in the family home. Services must be directly related to an identified goal in the POS and approved by the physician. Providers are identified through the person-centered planning / family-centered practice process and participate in the development of a POS based on strengths, needs and preferences of the child and family. Specialty services may include the following activities: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes in the goals, objectives and strategies identified in the POS based on the child=s progress. Services provided under Specialty Services include: Music Therapies, Recreation Therapies, Art Therapies, and Massage Therapies.

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

t._____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other State plan services (Specify):

u. _____ Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

_____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),

- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State of Michigan assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable

educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State of Michigan assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-2**PROVIDER QUALIFICATIONS**

1. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite Care	CMHSP, or an →	→ →	→ →	Medicaid enrolled
	Approved community-based mental health and developmental disability services provider	→ →	See Endnote a →	See Endnotes b and c
	Mental Health Aides →	→ →	→ →	As specified in the POS ; See Endnote d
	Foster Care Provider →	MCL 722.122 (Children); [Foster Care Licensure]	→ →	
	Licensed Nurse →	Current license under MCL 333.17201 Nursing Licensure from PA368 of 1978		Services may be provided in or out-of-home. - As specified in the plan of supports and services (POS)
Non-Family Training	CMHSP, or an →	→ →	→ →	Medicaid enrolled
	Approved community-based mental health and developmental disability services provider	→ →	See Endnote d →	See Endnotes b and c

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Non-Family Training – Con't.	Psychologist → Master's Level Social Worker → QMRP →	Current license under Part 18 of Michigan PA 368 of 1978, as amended → → → →	Current certification of registration under Michigan PA 352 of 1972, as amended → →	CFR 483.430
Specialty Services	CMHSP, or an → Approved community-based mental health and developmental disability services provider Therapeutic Recreation Specialist → Massage Therapist → Music Therapist → Art Therapist →	→ → → → → → → → → →	→ → See Endnote a → Certified by the National Council for Therapeutic Recreation (NCTRC) Certified by the National Certification Board for Therapeutic Massage & Bodywork (NCBTMB) Board Certified (MT-BC) National Music Therapy Registry (NMTR) Board Certified (ATR-BC) Credentials Board, Inc. (ATCB)	Medicaid enrolled See Endnotes b and c

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Environmental Modifications	CMHSP, or an → Approved community-based mental health and developmental disability services provider licensed builder →	→ → → → MCL 339.601 (1) MCL 339.601.2401 MCL 339.601.2404	→ → See Endnote a →	Medicaid enrolled See Endnotes b and c
Specialized Medical Equipment & Supplies	CMHSP, or an → Approved community-based mental health and developmental disability services provider	→ → → →	→ → See Endnote a →	Medicaid enrolled See Endnotes b and c
Transportation	CMHSP, or an → Approved community-based mental health and developmental disability services provider Public carriers; licensed individuals	→ → → → → →	→ → See Endnote a → → →	Medicaid enrolled See Endnotes b and c Holds a valid Michigan driver's license and has a good driving record
Community Living Supports	CMHSP, or an Approved community-based mental health and developmental disability services provider Mental Health Aide →	→ → → → → →	→ → See Endnote a → → →	Medicaid enrolled See Endnotes b and c As specified in the POS; See Endnote d

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Family Training	CMHSP, or an →	→ →	→ →	Medicaid enrolled
	Approved community-based mental health and developmental disability services provider	→ →	See Endnote a →	See Endnotes b and c
	Psychologist →	Current license under part 18 of Michigan PA 368 of 1978, as amended		
	Master's Level Social Worker →	→ →	Current certification of registration under Michigan PA 352 of 1972, as amended	
	QMRP →	→ →	→ →	CFR 483.430

Endnotes

- a. Must meet certification requirements as specified in Section 232a. of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto.
- b. Must be able to provide, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto.
- c. Must be Medicaid enrolled.
- d. Trained individuals performing respite care and/or community living supports must, in addition to the specific training, supervision and standards for each support/service, be:
 - Responsible adults, at least 18 years of age;
 - Free from communicable disease;
 - Able to read and follow written plans of service/supports as well as participant-specific emergency procedures
 - Able to write legible progress and/or status notes;
 - In “good standing” with the law, (i.e., not a fugitive from justice, a convicted felon or an illegal alien);
 - Successfully completed Recipient Rights Training;
 - Able to perform basic first aid and emergency procedures.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State of Michigan assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

 Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

 xx A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C - ELIGIBILITY and POST-ELIGIBILITY

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan.

(Check all that apply.)

- 1. xx Low income families with children as described in section 1931 of the Social Security Act.
- 2. xx SSI recipients (SSI Criteria States and 1634 States).
- 3. Aged, blind or disabled in 209(b) States who are eligible under ' 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
- 4. Optional State supplement recipients
- 5. xx Optional categorically needy aged and disabled who have income at (Check one):
 - a. xx 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL that is lower than 100%.
- 6. xx The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).
Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

 A. Yes xx B. No

Check one:

a. _____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. xx Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) xx A special income level equal to:

xx 300% of the SSI Federal benefit (FBR)

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

\$ which is lower than 300%

(2) Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5) Aged and disabled who have income at:

a. 100% of the FPL

b. % , which is lower than 100%.

(6) Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under '435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community ('435.217). For individuals whose eligibility is not determined under the spousal rules ('1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR '435.726 and '435.735 just as it does for other individuals found eligible under '435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under '1924.

REGULAR POST-ELIGIBILITY RULES--'435.726 and '435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--'1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of '1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The '1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in '1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the '1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. xx **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. § 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. x The following standard included under the State plan (check one):

(1) x SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___%

(5) ___ Other (specify):

B. ___ The following dollar amount: \$_____ *
* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ___ SSI standard

- B. ___ Optional State supplement standard
- C. ___ Medically needy income standard
- D. ___ The following dollar amount: \$ ___*
* If this amount changes, this item will be revised.
- E. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
- F. ___ The amount is determined using the following formula:
- G. ___ Not applicable (N/A)

3. Family (check one):

- A. ___ AFDC need standard
- B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State’s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

- C. ___ The following dollar amount: \$ ___*
*If this amount changes, this item will be revised.
- D. ___ The following percentage of the following standard that is not greater than the standards above: %
of ___ standard.
- E. The amount is determined using the following formula:
- F. ___ Other
- G. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___ **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

a. Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level: ___%

(5)___ Other (specify):

B. ___ The following dollar amount:
\$ ___*

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under '435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ___ The following standard under 42 CFR 435.121:

B. ___ The medically needy income standard _____;

C. ___ The following dollar amount: \$ _____ *

* If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of

E. ___ The following formula is used to determine the amount:

F. ___ Not applicable (N/A)

3. family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount: \$ _____ *

* If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

E. ___ Other

F. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of '1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under '1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:___%

(e)___ The following dollar amount
\$___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

_____ If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

- Discharge planning team
- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
- Other (Specify):

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- _____ Every 3 months
- _____ Every 6 months
- xx Every 12 months
- _____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

- xx The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- _____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):
 - _____ Physician (M.D. or D.O.)
 - _____ Registered Nurse, licensed in the State
 - _____ Licensed Social Worker
 - _____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
 - _____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- "Tickler" file
- Edits in computer system
- Component part of case management
- Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

- 1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

- By the Medicaid agency in its central office
- By the Medicaid agency in district/local offices
- By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
- By the case managers in the recipient=s case file at the CMHSP or other approved community based mental health and developmental disability services provider.
- By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
- By service providers
- Other (Specify):

- 2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to Appendix D-4

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:
STATE: Michigan

DATE: October, 2005

xx The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form used to document freedom of choice and to offer a fair hearing (see Waiver Certification form);
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver (see discussion under "Freedom of Choice" documentation below);
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services (see discussion under "Freedom of Choice" documentation below); and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E (see discussion under "Freedom of Choice").

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The Waiver Certification form, which documents freedom of choice for waiver services over ICF/MR placement, and the choice of service providers is maintained in the child's case file at the CMHSP or other approved community based mental health and developmental disability services provider, and in the Department of Community Health Central Office files. The issue of choice is discussed with the family prior to approval for waiver services and the implementation of the POS.

The Children's Waiver Technical Assistance Manual contains detailed instruction related to fair hearings, and is applicable to all actions and decisions involving consumers and the Children's Waiver Program. The instructions, documentation and forms contained in the Technical Assistance Manual are in conformance with the "Michigan Administrative Hearing Policy and Procedures" which is included in the Michigan Mental Health Code and in the CMHSP contracts. The Technical Assistance manual is distributed to all CMHSP staff, other agency providers and to parents upon request. It can also be found on the MDCH website. DCH tracks all Administrative Hearing decisions, including when a LOC change occurs. DCH will provide a summary of this analysis to CMS in the quality assurance impact component of the annual CMS 372 submission.

prepared by mary Clarkson 64650
date: 04-20-95
disk: streamlining
opus-3-d

Michigan Department of Community Health
Home and Community Based Children=s Waiver
Waiver Certification

1 Initial Certification 2 Annual Recertification
3 Child's Name 4 Medicaid # 5 Social Security #
6 Child's Address 7 City 8 State 9 Zip 10 Birthdate
8 Responsible Mental Health Authority 9 CMHSP Provider # 10 Clin. Serv. Prov. #

This is to certify that the above named child has received a comprehensive evaluation conducted by professional disciplines relevant to this child=s needs including physical, psychological, and social examinations. This comprehensive evaluation and supportive documentation are available in the child=s clinical record.

11 Waiver Recommended 12 Waiver Not Recommended
13 QMRP Date

Section 2

To be eligible, choose one item between #14, #15, or #16. Also #17 must be checked. Based on the results of the comprehensive evaluation and supportive documentation, the following eligibility requirements for the child are met:

- 14 This child is severely or profoundly retarded; or
15 This child is mildly or moderately retarded with multi-handicapping conditions or specific maladaptive behavior programming needs; or
16 This child is developmentally disabled and requires structured residential services similar to those required by, and provided for, mentally retarded persons.

AND

- 17 This child requires the types of services and the level of care provided by an intermediate care facility for the mentally retarded and would require ICF/MR placement, absent the waiver; and this child requires active treatment as defined per federal regulations.
18 Waiver Recommended: Yes No
19a Private Duty Nursing Intensity of Care (circle one) High Med Low Or
19b Category of Care Level/Determination (circle one): 1 2 3 4

20a Physician Date 21 Date CMHSP Provider Date
20b Physician Name Printed

Section 3

I understand that I may accept or reject waiver services instead of services provided in an ICF/MR. I accept/reject (circle one) services as offered under the Home and Community-Based Children=s Waiver. I am aware of my choice of qualified service providers.

22 Signature Date 23 Legal Guardian/Parent
24 Witness 1 Date

Waiver Enrollment: Section 4

25 Child is eligible for enrollment; effective: 26
Child enrollment status: 27a Deinstitutionalized 27b Diverted
28 Child is not eligible for enrollment 29 Enrollment terminated; effective: 30
31 Signature Date, Chair, Clinical Review Team

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

xx _____ Physician (M.D. or D.O.) licensed to practice in the State reviews and signs the Plan of Care.

_____ Social Worker (qualifications attached to this Appendix)

xx _____ Case Manager

xx _____ Other (specify):
The child, youth and family members are central to this process. Additionally, the disciplines participating in the development of the plan of care are determined through the person-centered planning / family-centered practice process and are based on the identified needs of the child.

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

xx _____ By case managers in the child=s case file

xx _____ By the agency specified in Appendix A for those children determined to have the most complex needs (Category I and Intensity of Care-High).

xx By consumers
_____ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months
_____ Every 6 months
xx Every 12 months
xx Other (specify):

In the Children's Waiver Program (CWP), the Choice Voucher System is a not a waiver service, rather it is a voluntary process that provides a concrete set of methods that enable waiver recipients and their families to control and direct how their individual plan of services and supports is implemented. The Choice Voucher System uses specific tools including a Children's Waiver Voucher Agreement, involvement of a qualified fiscal intermediary, and direct family-provider contracting. An individual plan of service and supports, developed through the person-centered planning / family-centered practice process, provides the basis for authorization of services and supports. With the exception of case management, authorized services include any or all Waiver-approved and/or State Plan services authorized by the CMHSP or other approved community-based mental health and developmental disability services provider. Families are able to hire qualified providers, as outlined in the Appendix B2, to provide the authorized services and supports. The elements of the system have been designed to meet the requirements of the Medicaid program and the CWP. System components make it possible for families to directly contract with providers by creating mechanisms to maintain accountability for service delivery and the

use of Medicaid funds, and provide support to the family in this process as needed.

The CMHSPs or other approved community-based mental health and developmental disability services providers are responsible for the everyday operations of the Choice Voucher System, to ensure that required contracts are secured and requirements met for their consumers. They maintain or have access to all required records and documentation. The CWP also provides oversight to ensure safeguards for consumers through on-site reviews using the CWP Site Review protocol.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The MDCH Division of Quality Management and Planning (QMP) conducts annual on-site visits to the PIHP/CMHSPs or other approved community based mental health and developmental disability provider. During these visits samples of Plans of care (POS) are reviewed. The MDCH Children's Waiver staff also complete periodic site reviews to the CMHSPs or other approved community based mental health and developmental disability services providers. During these site reviews the plans of care are reviewed. Additionally, MDCH Clinical Review Team reviews all plans of care for children whose needs are identified as qualifying for Category I or Intensity of Care-High (our highest levels of care). Decisions about Category of Care and Intensity of Care are made in conformance with policy as published in the applicable portions of the Michigan Medicaid Provider Manual, specifically the Children's Waiver Program and Private Duty Nursing. The Children's Waiver Technical Assistance Manual contains detailed procedures and methods for determining and documenting Category of Care and Intensity of Care.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

No standardized form is required. The POS will contain the information identified in b.1. above.

The Michigan Mental Health Code establishes the right for all individuals to have their individual plan of services developed through a person-centered planning (PCP) process regardless of age, disability or residential setting. Person-centered planning is a highly individualized process designed to plan and support the individual receiving services by building upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the individual desires or requires. Health and safety needs are addressed in the POS with supports listed to

accommodate those needs. The MDCH has advocated and supported a family-centered planning (FCP) approach to service delivery for children, youth and their families.

This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child is the focus of service planning, and family members are integral to the planning process and its success. Along with the health and safety needs of the child, the wants and needs of the child/family are considered in the development of the POS. The Children's Waiver Technical Assistance Manual contains detailed guidance on developing individualized plans of service.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

 xx Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

 Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

 Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

 Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. (See page 66, "CWP Billing Process") This includes a description of the mechanism in place to assure that all claims for payment of waiver services 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 approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

_____ Yes

xx No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

xx All claims are processed through an approved MMIS.

_____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

xx The Medicaid agency will make payments directly to providers of waiver services.

_____ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

xx Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):
CMHSP

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

The provider must be enrolled with Medicaid; all claims will be processed through Michigan's approved MMIS.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

prepared by mary clarkson 64650
date: 01-20-95
disk: streamlining
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CWP BILLING PROCESS

The CWP database is used to identify CWP recipients, the dates they became eligible for waiver services, and the dates they became ineligible for these services. This data file is e-mailed weekly to Michigan Medicaid Information System (MMIS) staff, and is used to set the CWP eligibility code and eligibility dates on MMIS. MMIS also contains Medicaid eligibility data for all Medicaid beneficiaries, including CWP recipients. When claims are submitted for payment, they are run against both Medicaid and CWP eligibility data to assure the beneficiary was eligible for Medicaid waiver payment on the date of service.

Billing and reimbursement for Children's Waiver services is handled in conformance with policies and procedures as stipulated in the Michigan Medicaid Provider Manual, and as elaborated in The Children's Waiver Technical Assistance Manual (May, 2004). Together, these manuals provide direction to CMHSPs and other approved providers regarding requirements for billing services for waiver recipients. Providers can find additional information on billing, reimbursement and third-party liability in the Medicaid Provider Manual, available on line at www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

The CWP site review includes a review of claims submitted to Medicaid by CMHSPs and other approved providers for the "most recent 6-month period". For each CWP recipient whose record will be reviewed, team members develop a chart to compare 3 elements: services listed on the budget, services billed to Medicaid, and services identified in the Individual Plan of Service (POS). This review process is used to assure that services billed to and paid by the CWP were included in the approved plan of care. (This review process is also used to assure the consumer receives services identified in the POS.)

APPENDIX G - FINANCIAL DOCUMENTATIONAPPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>\$25,793.86</u>	<u>\$24,522.00</u>	<u>\$159,370</u>	<u>\$1,847</u>
2	<u>\$24,653.47</u>	<u>\$31,922.08</u>	<u>\$164,608</u>	<u>\$1,996</u>
3	<u>\$24,613.48</u>	<u>\$35,759.11</u>	<u>\$170,019</u>	<u>\$2,158</u>
4	<u>\$24,386.48</u>	<u>\$40,057.36</u>	<u>\$175,607</u>	<u>\$2,333</u>
5	<u>\$24,409.00</u>	<u>\$44,872.25</u>	<u>\$181,379</u>	<u>\$2,522</u>

Note: All factors for year 1 are based on actual data from the most recently CMS-approved 372 report. Factors for years 2 through 5 are based on estimates.

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	<u>435</u>
2	<u>468</u>
3	<u>435</u>
4	<u>464</u>
5	<u>464</u>

EXPLANATION OF FACTOR C:

Check one: **D.C. NEEDS TO CHECK ONE**

 The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

XX The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages (pp. 84 through 86). Worksheets that document how columns B, C and D were derived follow Appendix G-8 and are on pages 18 through 20. Data from the CMS-approved annual 372 report for FY 2006 (i.e., the period 10/1/2005 through 9/30/2006) was used as the basis for calculation of the various elements of Factor D.

The unduplicated number of consumers using each service (column B) for waiver year 1 (2006) is taken directly from the 372 report, as are total expenditures for each service (column E). The unduplicated number of consumers using each service was also used to calculate the percent of consumers using each service in 2006, and this percentage was used to estimate the number of consumers who would be using services for waiver years 2 through 5 (2007 - 2010).

As the 372 report does not capture the average number of service units per consumer (column C), that number was derived for waiver year 1 by dividing the actual expenditure for each service by the number of consumers using the service times the average unit rate (column D). For waiver years 2 through 5, the average number of service units per consumer is the product of the column C estimate for year 1 times the estimated average length of stay for years 2 through 5.

No projected growth rate was built into the average unit cost per service; so column D is static for waiver years 1 through 5.

Please Note: When using actual 372 data for year 1, it is not possible to exactly match the 372 data for both expenditures and the unduplicated number of consumers using a service, when one must also estimate the average usage of each service. Our approach was to prepare the demonstration of Factor D based on the actual number of consumers using each service as reported on the 372 and the actual Factor D value (average per capital expenditures for waiver services) as reported on the 372, while keeping the "demonstration of expenditures" for each service as close as possible to expenditures as reported on the 372. You will note that, because the average number of units per user is a derived number, total expenditures for each service (column E) for year 1 are not an exact match with expenditures as reported on the 372 report. (E.g., the 372 indicates expenditures of \$140,316 for specialty services; and year 1 Factor D table shows expenditures of \$140, 304.36 for this service.)

APPENDIX G-2
 FACTOR D
 LOC: ICF/MR

Demonstration of Factor D Estimates:

WAIVER YEAR 1 (2006)

Waiver Service & Service Unit	Unduplicated No. Recipients (Users) Per Service	Average No. Of Units Per User (Annual)	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Family Training / per visit	146	10.58	\$62.50	\$96,542.50
2. Respite Care Services / per hour	397	558.86	\$16.78	\$3,722,935.31
3. Non-Family Training / per visit	262	9.52	\$62.09	\$154,867.36
4. Environmental Accessibility Adaptations & Specialized Medical Equipment / per home modification or equipment request	139	1	\$713.25	\$99,141.75
5. Specialty Services / per visit	84	28.31	\$59.00	\$140,304.36
6. Community Living Supports / per hour	362	1302.22	\$14.48	\$6,825,924.71
7. Enhanced Transportation / per mile	1	181.25	\$0.32	\$ 58.00
GRAND TOTAL (Sum of Column E)				\$11,039,773.99
TOTAL UNDUPLICATED # OF RECIPIENTS				428
FACTOR D (Divide grand total by # of recipients)				\$25,793.86
AVERAGE LENGTH OF STAY (expressed in months)				10.36 months

APPENDIX G-2
 FACTOR D
 LOC: ICF/MR

Demonstration of Factor D Estimates:

WAIVER YEAR 2 (2007)

Waiver Service & Service Unit	Unduplicated No. Recipients (Users) Per Service	Average No. Of Units Per User (Annual)	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Family Training / per visit	160	10.11	\$62.50	\$101,100.00
2. Respite Care Services / per hour	434	533.82	\$16.78	\$3,887,554.83
3. Non-Family Training / per visit	286	9.09	\$62.09	\$161,417.86
4. Environmental Accessibility Adaptations & Specialized Medical Equipment / per home modification or equipment request	152	1	\$713.25	\$108,414.00
5. Specialty Services / per visit	92	27.04	\$59.00	\$146,773.12
6. Community Living Supports / per hour	396	1243.88	\$14.48	\$7,132,507.43
7. Enhanced Transportation / per mile	1	173.13	\$0.32	\$ 55.40
GRAND TOTAL (Sum of Column E)			\$62.50	\$11,537,822.64
TOTAL ESTIMATED UNDUPLICATED # OF RECIPIENTS				468
FACTOR D (Divide grand total by # of recipients)				\$24,653.47
AVERAGE LENGTH OF STAY (expressed in months)				11.46 months

APPENDIX G-2
 FACTOR D
 LOC: ICF/MR

Demonstration of Factor D Estimates:

WAIVER YEAR 3 (2008)

Waiver Service & Service Unit	Unduplicated No. Recipients (Users) Per Service	Average No. Of Units Per User (Annual)	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Family Training / per visit	148	10.10	\$62.50	\$93,425.00
2. Respite Care Services / per hour	403	533.26	\$16.78	\$3,606,085.43
3. Non-Family Training / per visit	266	9.08	\$62.09	\$149,964.74
4. Environmental Accessibility Adaptations & Specialized Medical Equipment / per home modification or equipment request	141	1	\$713.25	\$100,568.25
5. Specialty Services / per visit	85	27.02	\$59.00	\$135,505.30
6. Community Living Supports / per hour	368	1242.58	\$14.48	\$6,621,261.49
7. Enhanced Transportation / per mile	1	172.95	\$0.32	\$ 55.34
GRAND TOTAL (Sum of Column E)				\$10,706,865.55
TOTAL ESTIMATED UNDUPLICATED # OF RECIPIENTS				435
FACTOR D (Divide grand total by # of recipients)				\$24,613.48
AVERAGE LENGTH OF STAY (expressed in months)				11.45 months

APPENDIX G-2
 FACTOR D
 LOC: ICF/MR

Demonstration of Factor D Estimates:

WAIVER YEAR 4 (2009)

Waiver Service & Service Unit	Unduplicated No. Recipients (Users) Per Service	Average No. Of Units Per User (Annual)	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Family Training / per visit	158	10.01	\$62.50	\$98,848.75
2. Respite Care Services / per hour	430	528.57	\$16.78	\$3,813,843.98
3. Non-Family Training / per visit	284	9.08	\$62.09	\$160,112.72
4. Environmental Accessibility Adaptations & Specialized Medical Equipment / per home modification or equipment request	151	1	\$713.25	\$107,700.75
5. Specialty Services / per visit	91	26.78	\$59.00	\$143,781.82
6. Community Living Supports / per hour	392	1231.64	\$14.48	\$6,990,985.70
7. Enhanced Transportation / per mile	1	171.43	\$0.32	\$ 54.86
GRAND TOTAL (Sum of Column E)				\$11,315,328.58
TOTAL ESTIMATED UNDUPLICATED # OF RECIPIENTS				464
FACTOR D (Divide grand total by # of recipients)				\$24,386.48
AVERAGE LENGTH OF STAY (expressed in months)				11.35 months

APPENDIX G-2
 FACTOR D
 LOC: ICF/MR

Demonstration of Factor D Estimates:

WAIVER YEAR 5 (2010)

Waiver Service & Service Unit	Unduplicated No. Recipients (Users) Per Service	Average No. Of Units Per User (Annual)	Average Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1. Family Training / per visit	158	10.02	\$62.50	\$98,947.50
2. Respite Care Services / per hour	430	529.13	\$16.78	\$3,817,884.60
3. Non-Family Training / per visit	284	9.01	\$62.09	\$158,878.38
4. Environmental Accessibility Adaptations & Specialized Medical Equipment / per home modification or equipment request	151	1	\$713.25	\$107,700.75
5. Specialty Services / per visit	91	26.81	\$59.00	\$143,942.89
6. Community Living Supports / per hour	392	1232.94	\$14.48	\$6,998,364.71
7. Enhanced Transportation / per mile	1	171.61	\$0.32	\$ 54.92
GRAND TOTAL (Sum of Column E)				\$11,325,773.75
TOTAL ESTIMATED UNDUPLICATED # OF RECIPIENTS				464
FACTOR D (Divide grand total by # of recipients)				\$24,409.00
AVERAGE LENGTH OF STAY (expressed in months)				11.36 months

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Not Applicable

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Respite care

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

SEE APPENDIX I-5, Pg. 21

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN
CAREGIVER

Check one:

XX The State will not reimburse for the rent and food expenses of an
unrelated live-in personal caregiver who lives with the individual(s)
served on the waiver.

_____ The State will reimburse for the additional costs of rent and food
attributable to an unrelated live-in personal caregiver who lives in the
home or residence of the individual served on the waiver. The service
cost of the live-in personal caregiver and the costs attributable to
rent and food are reflected separately in the computation of factor D
(cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State 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.

APPENDIX G-5
FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5
FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

- Based on HCFA Form 2082 (relevant pages attached).
- Based on HCFA Form 372 for years 1998 through 2003 of waiver #4119.90.R2, which serves a similar target population.
- Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- Other (specify):

Re: CMS Letter of August 11, 2005: Demonstration of Cost Neutrality for 1915(c) Home and Community-Based Services Waiver Programs After January 1, 2006 (in re: Medicare Part D prescription drugs):

There is no adjustment in D', as there are no dually-eligible (Medicare / Medicaid) consumers served by this Waiver; and there will be no Medicare Part D expenditures for CWP recipients effective January 1, 2006 and thereafter.

APPENDIX G-6
FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____ Based on trends shown by HCFA Form 372 for years _____ of waiver # _____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

_____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

_____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

XX Other (specify): The G values were computed in a manner equivalent to the way they would have been had the state been submitting the CMS 372 long form. Using MMIS data, total expenditures for ICF/MR and "acute"/State Plan care expenditures incurred on behalf of the ICF/MR inpatients during their admission were each divided by the number of unduplicated ICF/MR beneficiaries, rendering proxy G and G' values. The average rate of growth for these values was computed and applied to waiver years 1 through 5.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G. these costs in your calculation of Factor G.

APPENDIX G-7
FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) that began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7
FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

 Based on HCFA Form 2082 (relevant pages attached).

 Based on HCFA Form 372 for years of waiver
, which serves a similar target population.

 Based on a statistically valid sample of plans of care for individuals
with the disease or condition specified in item 3 of this request.

 XX Other (specify):

The G' values were computed in a manner equivalent to the way they would have been had the state been submitting the CMS 372 long form. Using MMIS data, total expenditures for ICF/MR and "acute"/State Plan care expenditures incurred on behalf of the ICF/MR inpatients during their admission were each divided by the number of unduplicated ICF/MR beneficiaries, rendering proxy G and G' values. The average rate of growth for these values was computed and applied to waiver years 1 through 5. The costs of prescription drugs for dual eligible individuals who will be covered by Medicare Part D effective 1/1/06 have been backed out of the State's projections. The impact of removing dual eligibles from G' was negligible.

APPENDIX G-8
DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1 - FY 2006

FACTOR D:	<u>\$25,793.86</u>	FACTOR G:	<u>\$159,370</u>
FACTOR D':	<u>\$24,522.00</u>	FACTOR G':	<u>\$ 1,847</u>
TOTAL:	<u>\$50,316.00</u> <	TOTAL:	<u>\$161,217</u>

YEAR 2 - FY 2007

FACTOR D:	<u>\$24,653.47</u>	FACTOR G:	<u>\$164,608</u>
FACTOR D':	<u>\$31,922.08</u>	FACTOR G':	<u>\$ 1,996</u>
TOTAL:	<u>\$56,575.55</u> <	TOTAL:	<u>\$166,604</u>

YEAR 3 - FY 2008

FACTOR D:	<u>\$24,613.48</u>	FACTOR G:	<u>\$170,019</u>
FACTOR D':	<u>\$35,759.11</u>	FACTOR G':	<u>\$ 2,158</u>
TOTAL:	<u>\$60,372.59</u> <	TOTAL:	<u>\$172,177</u>

APPENDIX G-8
DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: ICF/MR

YEAR 4 - FY 2009

FACTOR D:	<u>\$24,386.48</u>	FACTOR G:	<u>\$175,607</u>
FACTOR D':	<u>\$40,057.36</u>	FACTOR G':	<u>\$ 2,333</u>
TOTAL:	<u>\$64,443.84</u> <	TOTAL:	<u>\$177,940</u>

YEAR 5 - FY 2010

FACTOR D:	<u>\$24,409.00</u>	FACTOR G:	<u>\$181,379</u>
FACTOR D':	<u>\$44,872.25</u>	FACTOR G':	<u>\$ 2,522</u>
TOTAL:	<u>\$69,281.25</u> <	TOTAL:	<u>\$183,901</u>

prepared by mary clarkson 64650
date: 12-22-94 revised 04-13-95
disk: hcbs
opus-3-g

Estimated Number Of Recipients Using Each Service							
		2006		2007	2008	2009	2010
		# Recipients (actual) - FY 2006 Annual 372 Report	% Using Svc.				
	# Full Yr. Recip. -->	435		435	435	435	464
	# Added Each Year-->	0		33	0	29	0
	Undup. # Recip. (Total) -->	428		468	435	464	464
	Waiver Service						
	Family Training	146	34.11%	160	148	158	158
	Respite Care	397	92.76%	434	403	430	430
	Non-Family Training	262	61.21%	286	266	284	284
	Envir. Access. Adapt. / Spec. Med. Equip.	139	32.48%	152	141	151	151
	Specialty Services	84	19.63%	92	85	91	91
	Community Living Supports	362	84.58%	396	368	392	392
	Transportation	1	0.23%	1	1	1	1

Average Units Per Recipient Considering ALOS						
		Estimated from '06 Annual 372 Report	Projected			
		2006	2007	2008	2009	2010
	# Full Yr. Rec. -->		435	435	435	464
	# Added Each Year		33	0	29	0
	Undup. # Recip. (Total) -->	428	468	435	464	464
	ALOS Rate -->	86.30%	95.52%	95.42%	94.58%	94.68%
Waiver Service		# Units	Unit of Service			
Family Training		10.58	visits	10.11	10.10	10.01
Respite Care		558.86	hours	533.82	533.26	528.57
Non-Family Training		9.52	visits	9.09	9.08	9.00
Envir. Access. Adapt. / Spec. Med. Equip.		1	mods. or equip	1	1	1
Specialty Services		28.31	visits	27.04	27.02	26.78
Community Living Supports		1,302.22	hours	1243.88	1242.58	1231.64
Transportation		181.25	miles	173.13	172.95	171.43

Average Cost Per Unit Of Each Waiver Service						
		2006	2007	2008	2009	2010
	Projected Rate of Increase--->	0.00%	0.00%	0.00%	0.00%	0.00%
Waiver Service						
Family Training		\$62.50	\$62.50	\$62.50	\$62.50	\$62.50
Respite Care		\$16.78	\$16.78	\$16.78	\$16.78	\$16.78
Non-Family Training		\$62.09	\$62.09	\$62.09	\$62.09	\$62.09
Envir. Access. Adapt. / Spec. Med. Equip.		\$713.25	\$713.25	\$713.25	\$713.25	\$713.25
Specialty Services		\$59.00	\$59.00	\$59.00	\$59.00	\$59.00
Community Living Supports		\$14.48	\$14.48	\$14.48	\$14.48	\$14.48
Transportation		\$0.32	\$0.32	\$0.32	\$0.32	\$0.32

APPENDIX H: QUALITY MANAGEMENT STRATEGY

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 (pp. 89-99) to this Appendix H.

The Quality Management Strategy must describe how the state will determine that each waiver assurance is met. The description must include:

- Activities or processes related to discovery i.e. monitoring and recording the findings.*
- Roles and responsibilities of those involved in measuring performance and making improvements. Include administrative entities identified in Appendix A, and individuals, advocates, providers, etc.
- The sources of data used to measure performance.
- The frequency with which performance is measured.

* Descriptions of monitoring/over sight activities that occur at the individual and provider level of service delivery have been provided in the application in Appendices B, C, D, G, and I. These monitoring activities provide a foundation for QM by generating information that can be aggregated and analyzed to measure the overall performance of the system. The description of the QM Strategy does not have to repeat those descriptions provided in other parts of the waiver application. Note: Due to submission of the waiver application using the current application format, the above referenced Appendices are not applicable.

The Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.

The Quality Management Strategy must describe how the state compiles quality management information and communicates this information (in report or other forms) to participants, families, waiver providers, other interested parties, and the public, including the frequency of dissemination.

The Quality Management Strategy must include periodic evaluation and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.

If the State's Quality Management Strategy 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management Strategy spans more than one waiver and/or other types of long-term services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the Children's Waiver is designed to assess and improve the quality of services and supports provided to participants of Michigan's Children's Waiver Program (CWP). The state agency responsible for the components of the quality management system identified below resides in the Michigan Department of Community Health's (MDCH) Division of Quality Management and Planning, except where otherwise noted.

I. BACKGROUND: PROCESS FOR QUALITY MANAGEMENT STRATEGY MANAGEMENT REVIEW (QMS) AND REVISION

Since the approval of Michigan's 1915 (b)(c) waiver application in 1997, there has been a Quality Management Program (QMP) in place that is revised with each subsequent waiver renewal application. Michigan's original and subsequent QMPs have been developed with the input of consumers and the Mental Health Quality Improvement Council that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Services Boards (CMHSP). Michigan's most recent QMP, of which CMS is in receipt, reflects the activities, concerns, input and recommendations from the Michigan Mental Health Commission, MDCH's Encounter Data Integrity Team, MDCH's Administrative Simplification Process Improvement Team, the 2005 External Quality Review, and the terms and conditions from CMS' previous waiver approval.

Michigan uses a fee for service delivery system to provide services to its CWP recipients. CWP services are provided through CMHSPs and other approved community based mental health and developmental disability services providers. The MDCH contracts with Prepaid Inpatient Hospital Plans (PIHPs) that typically are composed of more than one CMHSP; in several instances a single CMHSP is a PIHP. Both the Division of Quality Management and Planning and the CWP within the Bureau of Community Mental Health Services of the MDCH review the CMHSPs and other approved community based mental health and developmental disability services providers, in part, through site visits. The purpose of the reviews is to monitor compliance with the Michigan Mental Health Code, the Medicaid Provider Manual, and the MDCH/CMHSP Contract. A site review protocol is used for all service areas, including the CWP. In addition, the staff working with the CWP may accompany the QMP staff to conduct a more detailed review of the CWP requirements using another site review protocol. They

also provide technical assistance to the agency staff. The CWP review includes evidence of a safe and appropriate IPOS, eligibility requirements, freedom of choice, service provider qualifications and contracts, administrative procedures, and Medicaid billings.

Though separate from the CWP, the existing infrastructure in Michigan includes 1915(b) waiver authority to allow Michigan to provide mental health services not otherwise covered under the State plan through a managed care delivery system. The combined 1915(b) with the 1915(c) Habilitation Supports Waiver (HSW) for individuals with developmental disabilities enables Michigan to use typical Medicaid managed care program features such as quality improvement performance plans and external quality reviews to effectively monitor waiver programs. These same quality improvement performance plans and external quality reviews are used to monitor approved providers in the provision of CWP services. Because the CWP is a fee for service program and is not covered under Michigan's managed care delivery system, the CMHSPs typically are the delivery point for accessing and utilizing CWP services.

II. CERTIFICATION, ACCREDITATION, AND LICENSURE

Community Mental Health Services Program Certification: The approved Plan for Procurement and the subsequent Application for Participation (2002) required that each PIHP be a community mental health services program (CMHSP). CMHSPs and other approved community based mental health and developmental disability services providers must meet certification requirements as specified in Section 232a of the Michigan Mental Health Code (Code), Public Act 158 of 1974, as amended, and the Administrative Rules applicable thereto. These entities must be able to provide, either directly or under contract a comprehensive array of services as specified in Section 206 of the Code.

It is required that the CMHSP, each of its subcontracting providers of mental health, and any other approved community-based mental health and developmental disability services provider meet these standards. If a CMHSP, approved community-based mental health and developmental disability services provider, or its sub-contracting provider is accredited by a national organization, a limited review of the accredited agency is conducted by MDCH beyond assuring the existence of said

accreditation.

MDCH has granted deemed status to four national accrediting bodies: Joint Commission on Accreditation of Health Care Organizations (JCAHO), CARF, The Council on Accreditation (COA), and The Council. Certification may be granted for up to three years. CMHSPs must be certified prior to entering into a pre-paid contract for services and supports for beneficiaries.

III. APPLICATION FOR PARTICIPATION (AFP) & CONTRACTUAL REQUIREMENTS FOR PIHPS' QUALITY MANAGEMENT SYSTEMS

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/PIHP contracts; and they are reviewed by MDCH staff and/or the external quality review process.

1. Customer Services: The following minimum standards for customer services are covered by the MDCH on-site visit or the External Quality Review (EQR): [Note: starred (*) items are covered by the EQR.]
 - a. Customer services operation is clearly defined
 - b. Customer service staff are knowledgeable about referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT)*
 - c. A range of methods is used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP's network
 - d. Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP*
 - e. The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice
 - f. Customer services is managed in a way that assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or

vision impairments, limited-English proficiency, and alternative forms of communications*

- g. The relationship of customer services to required appeals and grievances processes, and recipient rights processes, is clearly defined organizationally and managerially in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations*

PIHP found to be out of compliance with these standards must submit plans of correction. MDCH staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council (QIC). Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

2. Appeals and Grievances Mechanisms: The EQR reviews on-site the process, information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Appeals database to track the trends of the requests for fair hearing and their resolution and to identify PIHPs that have particularly high volumes of appeals. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

In addition, MDCH will utilize appeals data to assist in tracking changes in level of care (LOC) for all CWP participants. MDCH CWP staff will expand its LOC and Quarterly Review spreadsheet to track when a LOC change occurs, whether the participant's family appeals the change in LOC, and the Administrative Hearing results. MDCH will use appeals data to track LOC changes for CWP participants and will provide a summary of these results to CMS in the quality assurance component of CMS annual reports.

3. 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 on-site the PIHPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: sentinel events and credentialing of providers. MDCH collects data for performance indicators, performance improvement projects, as described below.

a. Performance Indicators

Please see Section VI.1 of this quality strategy.

b. Performance Improvement Projects

The MDCH staff collaborates to identify performance improvement projects for each waiver period. Justification for the projects was derived from analyses of quality management data, external quality review findings, and stakeholder concerns. For the upcoming waiver period, Michigan will require all PIHPs to conduct a minimum of two performance improvement projects:

- 1) All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH. In the case of PIHPs with affiliates, the project is affiliation-wide.
- 2) PIHPs that have continued difficulty in meeting a standard or implementing a plan of correction are assigned a project relevant to the problem. All other PIHPs choose a performance improvement project in consultation with the QAPIP governing body.

PIHPs report semi-annually on their performance improvement projects. The EQR validates the PIHPs methodologies for conducting the projects. Results of the MDCH performance improvement project reports are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

IV. EXTERNAL QUALITY REVIEW (EQR)

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the EQR for two years, beginning June 2004. HSAG worked

with MDCH and representatives from the PIHPs to adapt the Year One review protocols for Michigan. A similar approach will be employed for Year Two (June 2005-June 2006) and Year Three (June 2006-June 2007) of the EQR. The EQR consists of desk audits of PIHP documents and two-day on-site visits to each PIHP. The contents of the review for Years One, Two and Three are:

1. Validation of performance improvement projects
2. Validation of performance indicators
3. Compliance with Michigan's quality standards per BBA

Results of the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

V. MDCH ON-SITE REVIEW OF PIHPS: REVISED PROCESS FOR FY'06

The Division of Quality Management and Planning within MDCH monitors the CWP implementation at the 18 PIHPs (comprised of all the CMHSPs) and sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs for each fiscal year. MDCH has proposed to CMS the plan to conduct comprehensive biennial site visits to all PIHPs by the MDCH Division of Quality Management. During the alternate years state staff will visit PIHPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. As with the previous quality strategy, this site visit strategy incorporates for all beneficiaries served by the specialty waivers the more rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries, including visits to beneficiaries' homes. The comprehensive review includes the following components:

1. Clinical Record Review: Reviews of clinical records to determine that person-centered/family-centered planning is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and delivery of service meets program requirements that are published in the Medicaid Provider Manual. The MDCH review team draws random samples of clinical records to be reviewed from encounter data in the MDCH warehouse. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and all waiver programs, all affiliates (if applicable), a sample of providers, and a sample of individuals considered "at risk" (i.e., persons in

24-hour supervised settings and those who have chosen to move from those settings recently).

2. Administrative Review: The comprehensive administrative review will focus on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH/PIHP contract requirements, including:

- Compliance with the Medicaid Provider Manual
- Written agreements with providers and community agencies
- The results of the PIHPs' annual monitoring of its provider network
- Adherence to contractual practice guidelines
- Sentinel event management

3. Consumer/Stakeholder Meetings: During the biennial comprehensive review, the team will 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 planning, employment, recovery, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the PIHP's responsiveness to the group's concerns and suggestions.

4. Consumer Interviews: Review team members will conduct interviews with a random sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions on various topics, including awareness of grievance and appeals mechanisms, person-centered/family-centered planning, and satisfaction with services. Interviews will be conducted where consumers live for persons residing in group homes or persons living independently with intense and continuous in-home staff. Interviews of other consumers may be conducted in the PIHP office or over the telephone.

A report of findings from the on-site reviews will be disseminated to the PIHP with requirement that a plan of

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

CWP staff conducts additional on-site reviews. The CWP staff site review teams monitor the comprehensiveness and quality of the plans of care (POC). This is done through the on-site review of clinical records and consumer interviews, similar to the process described above. CWP consumers are interviewed in their family home. Based on site review team findings, a report is provided to the provider with the requirement that a plan of correction be submitted to MDCH in 30 days if the review staff identifies areas of improvement or non-compliance. Results of the CWP on-site reviews are shared with the MDCH Division of Quality Management and the MDCH contract manager. The Division of Quality Management conducts follow-up visits to confirm compliance with the plan of corrective action. Information shared with the MDCH contract managers is used by MDCH to take contract action as needed for system improvements.

On-site review teams look for evidence that POCs are updated or revised when participants' needs change. The POC must be updated at least annually. CWP participants are offered a choice of qualified providers. This is documented on the CWP Waiver Certification form.

VI. DATA SUBMISSION AND ANALYSES

1. Performance Indicators: Medicaid performance indicators measure the performance of the PIHPs. The QIC revised the performance indicators in 2005. Domains that include access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management categorize the indicators.

Indicators are used to alert MDCH management of systemic or individual PIHP issues that need to be addressed immediately; to identify trends to be watched; to monitor contractual compliance; and to provide information that the

public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in MDCH's data warehouse. Any data that is submitted in the aggregate by PIHPs, and the methodology for submission, are validated by MDCH and the EQR. Analysis of the data results in comparisons among PIHPs and with statewide averages. Statistical outliers are reviewed to identify best practices and opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may result in PIHP contract action. Technical information from the performance indicators is shared with the PIHPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

2. Encounter and Quality Improvement Data: Participant level encounter data is reported electronically in HIPAA-compliant format each month for all services, including CWP service, provided in the previous month and for which claims have been adjudicated. "Quality improvement" or demographic data are also reported monthly for each individual. Data are stored in MDCH's data warehouse where Medicaid Health Plan, Pharmacy encounter data, and fee for service data are also stored. Aggregate data from the encounter data system are shared with MDCH Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. The CWP staff review data from the warehouse for selected participants and for individuals whose records will be reviewed as part of an on-site review. This review process is used to ensure that services billed to and paid by the CWP were included in the approved POC. This review process is also used to assure the participant receives services identified in the POS.

3. Medicaid Sub-element Cost Data: PIHPs are required by contract to submit Medicaid sub-element cost reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided, by PIHP. 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 Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

The CWP database is used to identify CWP recipients and eligibility dates. This data file is used to update Michigan's Medicaid Information System (MMIS) weekly. When claims are submitted for payment, they are run against both Medicaid and CWP eligibility data to assure the beneficiary was eligible for Medicaid waiver payment on the date of service. This process, in conjunction with an annual MDCH review of the participants' budgets enables MDCH to manage to the amount appropriated to the CWP.

4. Sentinel Events: Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP for the following persons: those receiving Targeted Case Management (including the CWP), enrolled in the Habilitation Supports Waiver, live in 24-hour specialized residential settings, or living in their own homes and receiving personal care services. This information is reported in the aggregate to the MDCH semi-annually. Sentinel events include, but are not limited to: death of the recipient, any accident or physical illness that requires hospitalization, suspected abuse and neglect of a recipient, incidents that involve arrest or conviction of the recipient, serious challenging behaviors (e.g., property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence) and medication errors.

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

5. Recipient Rights: Semi-annually, local CMHSP ORRs report summaries of all allegations received and investigated, whether there was an intervention, and the number of allegations substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, right protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state ORR and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSP exist. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. MDCH is currently examining the possibility of cross matching waiver identifiers with the local ORR's data. If it is determined that a cross matching of waiver identifiers with local ORR data can be obtained, then the CWP will be able to separately report sentinel events and recipient rights allegations for CWP participants.

6. Service Agency Profiles: 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/addition of new providers, termination of contracts, change in accreditation status, change of address). This information is kept in a data base and is used by the Mental Health and Substance Abuse Administration to verify the capacity of the service network.

Appendix I: Financial Accountability

APPENDIX 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).

An annual Financial Status Report (FSR), certified by CMHSP Finance staff is submitted by each CMHSP. Children's Waiver Program (CWP) revenue and expenditures are uniquely identified on these FSRs, which also break out CWP expenses by federal, local, and state funding sources. During the contract reconciliation and cash settlement process, MDCH staff reconciles the CWP revenues reported by the CMHSP to the official MDCH records. Documentation for the contract reconciliation and cash settlement analysis is maintained in the Bureau of Finance.

Beginning with the 1998-2000 contract extension with MDCH, the CMHSPs and other qualified/approved community-based mental health and developmental disability services providers were obligated to implement the Federal Guidelines for Quality Assessment and Performance Improvement Programs (QAPIP). These guidelines were subsequently replaced with the administrative regulations promulgated as part of the Balanced Budget Act (BBA) of 1997. Among the Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: whether services claimed were listed in the Michigan Medicaid Provider Manual; whether services were identified in the person-centered plan; and verification of documentation that services claimed were actually provided. Sampling methodologies are used to conduct the Medicaid services verification reviews, which cover all Medicaid-reimbursed services. A report, known as the "Medicaid Services Verification Report", is submitted to and reviewed by MDCH's Division of QMP annually.

The PIHP/CMHSP 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.

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

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the PIHP/CMHSPs internal financial reports. These compliance exams are submitted to the MDCH Office of Audit.

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

The requirements for a Compliance Exam and the Financial Statement Audit do not replace or remove any other audit requirements that may exist, such as a Single Audit. If a PIHP or CMHSP expends \$500,000 or more in federal awards, they must obtain a Single Audit.

As the Medicaid enrolled mental health services provider, CMHSPs bill MDCH-MSA for CWP services. All claims submitted and accepted are processed through the Claims Processing (CP) System. MDCH encourages providers to send claims electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated. However, Paper claims can be submitted and they are scanned and converted to the same file format as claims submitted electronically. Claims processed through the CP system are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services and a combination of service edits. Once claims have been submitted and processed through the CP System, a paper remittance advice (RA) is sent to each provider with adjudicated or pended claims. An electronic health care claim payment/advice (ASC X12N 835 4010A1) is then sent to the designated primary service bureau for providers choosing an electronic RA. Michigan is mid-stream in design and implementation of the Community Health Automated Medicaid Processing System (CHAMPS) that will be used to process and pay all Medicaid claims, including fee-for-service payments for services provided to CWP consumers. The target date for implementation of CHAMPS is early 2009. Systems' requirements to enable processing CWP claims through CHAMPS have been included in all aspects of design for the new system.

The CWP Site Review Team reviews Medicaid billing invoices, budgets and POSs. The review ensures that the services billed were identified in the POS as appropriate to identified needs, were developed through a person-centered/family-center practice approach and were approved by the child and his/her family.

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.
- a.i** *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include*

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numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure/Indicator
<u>CWP claims are included in the annual Medicaid Services Verification audit completed by all participating CMHSPs and other qualified/approved community-based mental health and developmental disability services providers and reported to MDCH.</u>

Data Source (Select one):

Financial audits

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

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	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <u><i>Sampling methodologies are used to conduct the Medicaid Services Verification reviews, which cover all Medicaid-reimbursed services.</i></u>
	<input type="checkbox"/> Other Specify:	

Data Source (Select one):

Other

If 'Other' is selected, specify:

MDCH review of the Medicaid Services Verification Audit Reports

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

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<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Add another Performance measure (button to prompt another performance measure)

Performance Measure/Indicator
<u>All CWP claims are processed through the Medicaid (MSA) Claims Processing (CP) System and reviewed to ensure that: the code is billable; the submitted quantity and frequency is within the established parameters for quantity and frequency; and is paid at the lesser of the charge or the</u>

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Performance Measure/Indicator

Medicaid fee screen.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic claims submitted by the CMHSPs to Medicaid

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

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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

The PIHP/CMHSP and other qualified/approved community-based mental health and developmental disability services providers monitor claims through the services verification review process described in I-1 above. A final report is prepared which details findings and discrepancies with financial implications, and corrective action taken or to be taken. In those instances where a recommendation is made regarding internal procedures, PIHP/CMHSP staff 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.

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

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b.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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

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

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APPENDIX I-2: Rates, Billing and Claims

- 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).

Overview: Provider payment rates in the form of Medicaid fee screens are established by the Medicaid Agency, published on the Medicaid web site and are available to providers, waiver participants and the general public. All waiver service providers are paid uniformly at the lesser of their charges or the established Medicaid fee screen. Because Medicaid fee screens have not kept pace with increasing costs, many CMHSPs must use local, non-Medicaid resources to fund the costs that exceed the Medicaid fee screens. As additional state appropriations to the MDCH are not available to support an increase in Medicaid fee screens for CWP services, the MDCH has developed a methodology for adjusting payments to CMHSPs for services provided to CWP consumers. For purposes of this discussion, the term “interim screen” or “interim fee screen” refers to the established Medicaid fee screen used to pay claims as submitted to the Medicaid invoice processing system (detailed in I-2 b. below). The term “final fee screen” is used to denote the adjusted maximum amount payable for each service, determined via the methodology outlined below at year-end. Those providers whose costs / charges exceeded the interim screen will provide the non-federal share (i.e., 1-FMAP) for the Medicaid payment difference accruing from the final fee screens, and will do so in the form of an intergovernmental transfer. Payments to providers will be adjusted to final once a year. The final fee screens are set to the Medicare Physicians Fee Schedules where applicable, and to the 90 percentile of provider charges for those without a fee published within the Medicare Physicians Fee Schedule. Detail regarding the proposed method for determining the final fee screen for each waiver and state plan service available to CWP participants is outlined under “Methodology Detail” below.

Responsible Entity (-ies): Within MDCH, Michigan’s Single State Medicaid Agency, the Medical Services Administration (MSA) establishes the interim fee screens (i.e., provider payment rates); the Mental Health and Substance Abuse Administration (MH&SAA) in collaboration with MSA implements the methodology that results in the final fee screens. Oversight of the final fee screen (rate) determination methodology is provided by the staff of MSA and MH&SAA. Both the interim and final fee screens are reviewed by the Budget, Accounting and Audit Offices within MDCH.

Public Comment: The interim and final fee screens are presented and comments solicited from attendees of the CWP track of the annual CWP – HSW conference. This conference is well publicized and well attended by waiver participants, their families and friends, and a wide variety of the key/invested stakeholders.

Informing Waiver Participants About Service Rates: As noted in the overview, above, the rates are published on the MDCH web site. The interim and final fee screens are also available to participants as well as the general public in written form when requested.

Methodology Detail: The methodology outlined below combines the strengths of Medicare’s RBRVS-based Physician’s Fee Schedule, the 90th percentile of charges method used by third party payers throughout the health care industry, and pricing conventions from Michigan’s current CWP

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fee screens [applicable to procedures provided to more than one beneficiary at a time and/or those eligible for a holiday premium rate]. The goal of the adjustment is assure the federal reimbursement for these Medicaid covered services is calculated based on their full cost and reimbursed consistent with the applicable Federal Medical Assistance Percentages. The steps of the “adjust interim to final fee screens” methodology are the following:

- 1) Draw from the MDCH Data Warehouse the fee for service claims experience for the beneficiary ID #'s of CWP enrollees [qualifying those ID against PT 77 and the CMH Clinic specialty code 0253] for FY 2006, Q4 FY 2006, and FY 2007. For each procedure for which there was one or more claim(s), query the Data Warehouse for: a) the billing CMHSP, b) a distinct count of the beneficiaries receiving, c) the total units claimed, d) the total charges and, e) the total payments. Perform a parallel query for those procedures subject to holiday premium payments for the holidays within each of the date ranges, subtract the units, charges and payments for the holiday dates from the base data to assure no duplication and display them separately [at the bottom of each of the date range tabs]. **Note:** CMHSP's are bound by their Medicaid Provider Agreements and Master Contracts with MDCH to assure their charges are determined consistent with Generally Accepted Accounting Principles and OMB Circular A-O87.
- 2) Remove from fee screen adjustment to final consideration those claimed procedures for which adjustment makes no sense [e.g., the item and payment amount is prior authorized, includes up to “x” items for a maximum charge, or the items covered under the fee screen are diverse and charges aren't necessarily the same, etc.]. The follow eight codes will be excluded from adjustment: E1340, E1399, S5165, S5199, T1999, T2028, T2029, T2039.
- 3) Calculate average charge per unit [total charges/total units] for each CMHSP billing for each procedure, and array the average unit charges for each procedure in descending order.
- 4) Review each of the claimed procedures for a corresponding “non-facility fee” within the Medicare Physicians Fee Schedule for Michigan, and where one exists set it as the final CWP fee screen.
- 5) Where claimed procedures have no corresponding fee within the Medicare Physicians Fee Schedule for Michigan, calculate the 90th percentile of the arrayed average unit charges and set the result as the final CWP fee screen.
- 6) Consistent with the existing CWP fee screen protocol, the screens for procedures provided to more than one beneficiary at a time, are designated with a TT modifier and will be set at 75% of the corresponding unmodified procedure's final fee screen (e.g., final fee screen for T1005 TT will be set at 75% of T1005's adjusted screen).
- 7) Also consistent with the existing CWP fee screen protocol, the screens for procedures eligible for a holiday premium and provided on holidays will be set at 150% of the corresponding unmodified procedure's final fee screen (e.g., adjusted fee screen for H2015 provided on Christmas day will be set at 150% of H2015's adjusted screen).

For those procedures billed by only one CMHSP and to which none of the above rules apply, the existing screen will be used and no adjustment to final will be made.

The State of Michigan is requesting approval to implement a cost adjustment for fiscal years 2008 and 2009, with the understanding that **no facility will be paid more than the cost of providing**

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services. Michigan agrees to work with CMS to clarify the policy regarding OHCDs rate setting requirements. Changes will be implemented in conjunction with the October 1, 2010 renewal process.

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:

For services provided to CWP enrollees, CMHSPs and other qualified/approved community-based mental health and developmental disability services providers bill Medicaid in accordance with policies and procedures published in the “Billing and Reimbursement for Professionals” section of the Michigan Provider Manual. That portion of the Manual also contains information about how claims are processed and how providers are notified of MDCH actions.

CMHSPs and other qualified/approved community-based mental health and developmental disability services providers must use the ASC X12N 837 4010 A1 professional format when submitting electronic claims and the CMS 1500 claim form for paper claims. All claims submitted and accepted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically. Claims processed through the CP system are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services and a combination of service edits. MDCH encourages providers to send claims electronically by file transfer or through the data exchange gateway (DEG). Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated.

c. Certifying Public Expenditures (select one):

<input type="radio"/>	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 (<i>check each that applies</i>):
<input type="checkbox"/>	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). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	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). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
<input checked="" type="checkbox"/>	No. State or local government agencies do not certify expenditures for waiver services.

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

(a) Claims processed through the CP system described in b. above are edited for many parameters, including that the consumer was enrolled in the CWP and Medicaid on the date of service, that the service was one that could be billed on the date of service (procedure validity), and all other edits built into the system (e.g., claim duplication, frequency and quantity limitations).

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

The CWP Site Review Team reviews Medicaid billing invoices, budgets, POSs, case notes, assessments and reports. The review ensures that the services billed were identified in the POS as appropriate to identified needs, were recommended by the child’s team, approved by the child’s family, and that the services were provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (select one):

<input checked="" type="checkbox"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="checkbox"/>	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) 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.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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:

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*):

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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.

- 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:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	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.

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

<input checked="" type="radio"/>	Yes. State or local government providers receive payment for waiver services. 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. <i>Complete item I-3-e.</i>
The providers of CWP services include CMHSPs and other qualified/approved community-based mental health and developmental disability services providers.	
<input type="radio"/>	No. State or local government providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

- 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:*

<input checked="" type="radio"/>	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	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.
<input type="radio"/>	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:

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:*

<input checked="" type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input type="radio"/>	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.
<input checked="" type="radio"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

<input checked="" type="radio"/>	<p>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:</p> <p>CMHSPs are considered Organized Health Care Delivery Systems (OHCDs). In a participating geographical area other mental health service providers may enroll with Medicaid and provide CWP services if they meet the requirements of the Michigan Mental Health Code as an approved community based mental health and developmental disability services provider.</p> <p>All direct service providers (e.g., CLS, respite) must: 1) be employed by the CMHSP or other approved community based mental health and developmental disability services provider; or 2) be part of the CMHSPs or other approved community based mental health and developmental disability services provider's network; or 3) have a current contract with the CMHSP or other approved community based mental health and developmental disability services provider. All direct service providers (e.g., CLS, respite) must meet qualifications as detailed in the CWP approved waiver application and the Michigan Medicaid Provider Manual. CWP enrollees have freedom to choose among qualified service providers.</p>
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	<p>When clinical and administrative records for CWP enrollees are selected for an on-site review, records are sampled from each participating CMHSP or other approved community based mental health and developmental disability services provider. As detailed elsewhere in this renewal application, the on-site review of clinical and administrative records includes a detailed review of provider qualifications and agency contracts – including whether the contract contains clear performance expectations.</p> <p>The process for financial accountability is the same whether the provider is a CMHSP or other approved community based mental health and developmental disability services provider. All CMHSPs and other approved community based mental health and developmental disability service providers are required to submit the same annual Financial Status Reports (FSRs) to MDCH and are subject to the same auditing requirements.</p> <p>Michigan agrees to work with CMS to clarify the policy regarding OHCDs cost reporting requirements. Changes will be implemented in conjunction with the October 1, 2010 renewal process.</p>
○	<p>No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.</p>

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

○	<p>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 <i>voluntarily</i> elect to receive <i>waiver</i> 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.</p>
○	<p>This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.</p>
X	<p>The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.</p>

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APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

<input type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	<p>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:</p> <p>The source of the non-federal share to MDCH Administration is funded through an appropriation of tax revenue paid to the CMHSPs as General Fund-formula funds. Should the CMHSP not have adequate local funds to provide local match they may use their general fund dollars.</p>
<input type="checkbox"/>	<p>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:</p>

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. *Check each that applies:*

<input checked="" type="checkbox"/>	<p>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:</p> <p>(a) & (b) County Boards of Commission have the authority to levy taxes and allocate a portion of general county funds (including property tax revenue) to CMHSPs to be used as local match. Cities and townships also have authority to appropriate funds to CMHSPs.</p> <p>(c) An Intergovernmental Transfer (IGT) will be used to execute the year end adjustment. Those CMHSPs whose charges to Medicaid (i.e., whose costs) exceeded the interim fee screen will wire the Medicaid agency the state portion (1-FMAP) of the amount above the interim fee screen and at or below the final fee screen.</p>
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<input checked="" type="checkbox"/>	<p>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:</p> <p>(a) & (b) In addition to the funds raised through local (i.e., county/city/etc) taxing authority and appropriated to CMHSPs, the CMHSPs receive State non-Medicaid general fund / general purpose (GF/GP) funding to discharge their contractual obligations under the State’s Mental Health Code. These State GF/GP non-Medicaid funds are the primary source of the non-federal share (i.e., 1-FMAP) discussed throughout Appendix I.</p> <p>(c) An Intergovernmental Transfer (IGT) will be used to execute the year end adjustment. Those CMHSPs whose charges to Medicaid (i.e., whose costs) exceeded the interim fee screen will wire the Medicaid agency the state portion (1-FMAP) of the amount above the interim fee screen and at or below the final fee screen.</p>
<input type="checkbox"/>	<p>Not Applicable. There are no local government level sources of funds utilized as the non-federal share.</p>

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:*

<input checked="" type="checkbox"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="checkbox"/>	The following source (s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
	For each source of funds indicated above, describe the source of the funds in detail:

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

a. Services Furnished in Residential Settings. *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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:

As stated in the Michigan Medicaid Provider Manual, respite care services can be provided in the child’s home, foster home, licensed respite care facility, licensed camp, or the home of a friend or relative who meet provider qualifications. Cost of room and board cannot be included as part of respite care. DHS, Michigan's child welfare organization, licenses and regulates these facilities: Room and Board rates are as follows:

a.) Age birth - 12: \$14.24 a day
 b.) Age 13 - 18: \$17.59 a day

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APPENDIX 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:

<input type="radio"/>	<p>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. <i>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:</i></p> <div style="border: 1px solid black; height: 50px; width: 100%; background-color: #e0e0e0;"></div>
<input checked="" type="radio"/>	<p>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.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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:*

<input checked="" type="radio"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

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

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

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

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge
Answers provided in Appendix I-7-a indicate that you do not need to complete this section.		

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one):*

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

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

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b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	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: <div style="background-color: #cccccc; height: 40px; width: 100%; margin-top: 5px;"></div>

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