MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-27

Distribution: Medicaid Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice), Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Centers for Independent Living

Issued: July 1, 2011

Subject: MI Choice Policy Chapter

Effective: August 1, 2011

Programs Affected: Medicaid

Medicaid's MI Choice home and community based waiver program has provided services and supports to elderly and disabled people in Michigan since 1992. Since that time, the waiver has been amended, renewed and revised multiple times, but the policy, rules, regulations and operating standards that govern operation of MI Choice have never been consolidated into a single document and incorporated into the Medicaid Provider Manual.

The purpose of this bulletin is to introduce a new chapter to the Medicaid Provider Manual that focuses specifically on MI Choice. It consolidates the essential policy components that govern the program into a single, comprehensive document that conveys necessary guidance for waiver agencies and program providers in delivering program services.

Effective August 1, 2011, the MI Choice Waiver Program Admission and Eligibility Process (January 2010) will be removed from the website.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton

Stephen Fitton, Director
Medical Services Administration

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SECTION 1 – GENERAL INFORMATION

MI Choice is a waiver program operated by the Michigan Department of Community Health (MDCH) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria that supports required long-term care (as opposed to rehabilitative or limited term stay) provided in a nursing facility. The waiver is approved by the Centers for Medicare and Medicaid Service (CMS) under section 1915(c) of the Social Security Act. MDCH carries out its waiver obligations through a network of enrolled providers that operate as organized health care delivery systems (OHCDS). These entities are commonly referred to as waiver agencies. MDCH and its waiver agencies must abide by the terms and conditions set forth in the waiver.

MI Choice services are available to qualified participants throughout the state and all provisions of the program are available to each qualified participant unless otherwise noted in this policy and approved by CMS. MDCH will not enact any provision to the MI Choice program that prohibits or inhibits a participant's access to a person-centered plan of service, discourages participant direction of services, interferes with a participant's right to have grievances and complaints heard, or endangers the health and welfare of a participant. The program must monitor and actively seek to improve the quality of services delivered to participants. Safeguards are utilized to ensure the integrity of payments for waiver services and the adequacy of systems to maintain compliance with federal requirements.

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SECTION 2 - ELIGIBILITY

The MI Choice program is available to persons 18 years of age or older who meet each of three eligibility criteria:

- An applicant must establish his/her financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.
- The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- It must be established that the applicant needs at least one waiver service and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met in order to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program.

Waiver agencies are required to provide oral and written assistance to all Limited English Proficient applicants and participants. Agencies must arrange for translated materials to be accessible or make such information available orally through bi-lingual staff or through the use of interpreters.

2.1. FINANCIAL ELIGIBILITY

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by the Michigan Department of Human Services (MDHS). As a provision of the waiver, MI Choice applicants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is furnished to individuals in the special home and community-based group under 42 CFR §435.217 with a special income level equal to 300% of the SSI Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend down to achieve an enhanced financial eligibility standard.

2.2. FUNCTIONAL ELIGIBILITY

The MI Choice waiver agency must verify applicant appropriateness for services by completing the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) within 14 calendar days after the date of participant's enrollment. Refer to the Directory Appendix for website information. The LOCD is discussed in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter. Additional information can be found in the Nursing Facility Coverages Chapter and is applicable to MI Choice applicants and participants.

The applicant must also demonstrate a continuing need for at least one covered MI Choice service. This need is originally established through the Initial Assessment using the process outlined in the Need For MI Choice Services subsection of this chapter.

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2.2.A. MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

MI Choice applicants are evaluated for functional eligibility via the Michigan Medicaid Nursing Facility Level of Care Determination. The LOCD is available online through Michigan's Single Sign-on System. Refer to the Directory Appendix for website information. Applicants must qualify for functional eligibility through one of seven doors.

These doors are:

- Door 1: Activities of Daily Living Dependency
- Door 2: Cognitive Performance
- Door 3: Physician Involvement
- Door 4: Treatments and Conditions
- Door 5: Skilled Rehabilitation Therapies
- Door 6: Behavioral Challenges
- Door 7: Service Dependency

The LOCD must be completed in person by a health care professional (physician, registered nurse (RN), licensed practical nurse (LPN), licensed social worker (BSW or MSW), or a physician assistant) or be completed by staff that have direct oversight by a health care professional.

The online version of the LOCD must be completed within fourteen (14) calendar days after the date of enrollment in MI Choice for the following:

- All new Medicaid-eligible enrollees
- Non-emergency transfers of Medicaid-eligible participants from their current MI Choice waiver agency to another MI Choice waiver agency
- Non-emergency transfers of Medicaid-eligible residents from a nursing facility that is undergoing a voluntary program closure and who are enrolling in MI Choice

Annual online LOCDs are not required, however, subsequent redeterminations, progress notes, or participant monitoring notes must demonstrate that the participant continues to meet the level of care criteria on a continuing basis. If waiver agency staff determines that the participant no longer meets the functional level of care criteria for participation (e.g., demonstrates a significant change in condition), another face-to-face online version of the LOCD must be conducted reflecting the change in functional status. This subsequent redetermination must be noted in the case record and signed by the individual conducting the determination.

Copies of the LOCD for participants must be retained by the waiver agency for a minimum period of six years. This information is also retained in the MDCH LOCD database for six years.

2.2.B. FREEDOM OF CHOICE

Applicants or their legal representatives must be given information regarding all long-term care service options for which they qualify through the NF LOCD, including MI Choice, Nursing Facility and the Program of All-Inclusive Care for the Elderly (PACE). That a participant might qualify for multiple programs does not mean they can be served by all or a combination thereof for which they qualify. Nursing facility, PACE, MI Choice, and Adult Home Help services may not be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options via the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the individual (or his/her legal representative) seeking services and is to be maintained in the participant case record.

2.2.C. RETROSPECTIVE REVIEW AND MEDICAID RECOVERY

MDCH or its designee will perform retrospective reviews to validate the LOCD as performed by waiver agencies. The waiver agency must submit all supporting medical documentation requested by MDCH or its designee. If the applicant is found to be ineligible for MI Choice, MDCH will recover all Medicaid payments made for the services rendered during the period of ineligibility by making an adjustment during annual cost reconciliation.

Determinations resulting from such retrospective reviews may be appealed by the waiver agency through procedures established by MDCH. MI Choice participants or applicants may not appeal retrospective review decisions.

2.3. NEED FOR MI CHOICE SERVICES

In addition to meeting financial and functional eligibility requirements and to be enrolled in the program, MI Choice applicants must demonstrate the need for a minimum of one covered service as determined through an in-person assessment and the person-centered planning process.

Note: Supports coordination is considered an administrative activity in MI Choice and does not constitute a qualifying requisite service. Similarly, informal support services do not fulfill the requirement for service need.

An applicant cannot be enrolled in MI Choice if his/her service and support needs can be fully met through the intervention of State Plan or other available services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications.

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2.3.A. INITIAL ASSESSMENT OF PARTICIPANTS

The MI Choice program has established the Resident Assessment Instrument – Home Care (iHC) as the approved assessment instrument for assessing the functional status of participants. It is compatible with the federally mandated Minimum Data Set for Home Care (MDS-HC). The Telephone Intake Guideline (TIG), LOCD, and the iHC are not interchangeable assessment tools.

Initial assessments are conducted by teams consisting of a minimum of a registered nurse and a social worker, both of whom are properly licensed by the State of Michigan.

2.3.B. REASSESSMENT OF PARTICIPANTS

Reassessments are conducted by either a properly licensed registered nurse or a social worker, whichever is most appropriate to address the circumstances of the participant. A team approach that includes both disciplines is encouraged whenever feasible or necessary. Reassessments are done in person with the participant at the participant's home.

MI Choice uses a case status classification system to determine the reassessment and service plan review and the update schedule for program participants. Supports coordinators designate a case status for each participant at the time of service plan development or reassessment using professional judgment in determining participant needs.

Participants classified with active status are those individuals with the most difficult, unstable, or complex needs that require more intensive involvement. Supports coordinators classify participants as active when it is determined that the participant requires a reassessment every 90 days or more frequently when necessary.

Participants classified with maintenance status are more physically stable and less complex than active cases. Monitoring is required less frequently. At the time of the second reassessment (180 days), the supports coordinator may designate the participant as on maintenance status. Subsequent to the second reassessment, the supports coordinator may designate maintenance status when the participant's situation is currently stable. The participant's level of frailty, risk, or illness determines that the participant requires a reassessment every 180 days or more frequently when necessary.

Supports coordinators may change the case status classification of participants as indicated upon reassessment. Regardless of a defined case status classification, participants may refuse reassessment. The supports coordinator must note this refusal in the case record. However, to maintain program eligibility, the supports coordinator must assess all program participants at least every 180 days. A refusal which prevents a redetermination within the 180-day window is cause for termination from the program.

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SECTION 3 - ENROLLMENT

MI Choice waiver agencies determine the enrollment and termination dates for each participant for whom they provide waiver services. No participant shall be granted enrollment status without fully meeting all eligibility requirements. Participants must agree to accept at least one waiver service on a continual basis in order to be enrolled in MI Choice. When a potentially eligible applicant cannot be enrolled due to the agency being at capacity, the applicant is placed on a waiting list. Refer to the Waiting Lists subsection for additional information.

3.1. GENERAL PROVISIONS OF PARTICIPATION

There are a number of circumstances that play a role in the eligibility status of MI Choice participants. The following sub-sections define these impacts.

3.1.A. ENROLLMENT IN MEDICAID HEALTH PLANS AND OTHER PROGRAMS

A program participant may not be simultaneously enrolled in both MI Choice and a Medicaid Health Plan, PACE program, or any other §1915(c) waiver. Applicants must choose one program in which they wish to enroll. It is not necessary to either delay MI Choice enrollment or withhold MI Choice services pending the disenrollment process from any of the Medicaid Health Plans.

3.1.B. INSTITUTIONAL STAYS

There are occasions when a MI Choice participant might require a short-term admission to an institutional setting for treatment. The impact of such an institutional stay is dependent on the type of admission and the length of the stay.

A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of waiver services during the hospital stay to avoid unnecessary or redundant service delivery from the hospital or MI Choice, however the supports coordinator should not remove the individual from MI Choice. A participant who is hospitalized for more than 30 days must have his/her enrollment suspended.

A participant admitted to a nursing facility for rehabilitation services or for any reason must be removed from MI Choice on the date prior to the nursing facility admission. The person may be re-enrolled into MI Choice upon discharge from the nursing facility, subject to the enrollment status of the agency.

3.2 TELEPHONE INTAKE GUIDELINES

The Telephone Intake Guidelines (TIG) are a list of questions designed to screen potential MI Choice program participants for potential eligibility and further assessment. Additional probative questions are permissible when needed to clarify potential eligibility. The TIG does not in itself establish program eligibility. Use of the TIG is mandatory for MI Choice waiver agencies prior to placing applicants on a MI Choice waiting list when the agency is operating at its capacity. The date of the TIG contact establishes the chronological placement of the applicant on the waiting list. The TIG may be found on the MDCH website. Refer to the Directory Appendix for website information.

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Persons who request services in MI Choice must be screened by telephone using the TIG at the time of his/her request. If the caller is seeking services for another individual, the waiver agency shall either contact the person for whom services are being requested, or complete the TIG to the extent possible using information known to the caller. For applicants who are deaf, hearing impaired, or otherwise unable to participate in a telephone interview, it is acceptable to use an interpreter, a third-party participant in the interview, or assistive technology to facilitate the exchange of information.

As a rule, nursing facility residents who are seeking to transition into MI Choice are not contacted by telephone but rather are interviewed in the nursing facility. For the purposes of establishing a point of reference for the waiting list, the date of the initial nursing facility visit shall be considered the same as conducting a TIG, so long as the functional and financial objectives of a TIG are met. Specifically, the interview must establish a reasonable expectation that the applicant will meet the functional and financial eligibility requirements of the MI Choice program within the next 60 days.

Applicants who are expected to be ineligible based on TIG information may request a face-to-face evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination and financial eligibility criteria. Such evaluations should be conducted as soon as possible, but must be done within 10 business days of the date the TIG was administered. MI Choice waiver agencies must issue an adverse action notice advising applicants of any and all appeal rights when the applicant appears ineligible either through the TIG or a face-to-face evaluation.

When an applicant appears to be functionally eligible based on the TIG, but is not expected to meet the financial eligibility requirements, the MI Choice waiver agency must place the applicant on their waiting list if it is anticipated that they might become financially eligible within 60 days. Individuals may be placed on the waiting lists of multiple waiver agencies.

The TIG is the only recognized tool accepted for telephonic screening of MI Choice applicants.

3.3 ENROLLMENT CAPACITY

MI Choice capacity is limited to the number of individuals who can be adequately served under the annual legislative appropriation for the program. Enrollment capacity for each individual waiver agency is at the agency's discretion based on available funding and the expected costs of maintaining services to enrolled participants.

Capacity is not determined by an allocated number of program slots. While numbers of slots must be monitored for federal reporting purposes, waiver agencies are expected to enroll any participant for whom they have resources to serve.

3.4 WAITING LISTS

Whenever the number of persons receiving and applying for services through MI Choice exceeds the existing program capacity, any applicant must be placed on the waiver agency's waiting list. Waiting lists must be actively maintained and managed by each MI Choice waiver agency. The enrollment process for the MI Choice program is not ever actually or constructively closed. The applicant's place on the waiting list is determined by priority category in the order described below. Within each category, an applicant is placed on the list in chronological order based on the date of his/her request for services. This is the only approved method of accessing waiver services when the waiver program is at capacity.

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3.4.A. PRIORITY CATEGORIES

Applicants will be placed on a waiting list by priority category and then chronologically by date of request of services. Enrollment in MI Choice is assigned on a first come/first served basis using the following categories, listed in order of priority given:

3.4.A.1. CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS) AGE EXPIRATIONS

This category includes only those persons who continue to require Private Duty Nursing services at the time such coverage ends due to age restrictions under CSHCS.

3.4.A.2. NURSING FACILITY TRANSITION PARTICIPANTS

Nursing facility residents who desire to transition to the community and will otherwise meet enrollment requirements for MI Choice qualify for this priority status and are eligible to receive assistance with supports coordination, transition activities, and transition costs. Priority status is not given to applicants whose service and support needs can be fully met by existing State Plan services.

3.4.A.3. CURRENT ADULT PROTECTIVE SERVICES (APS) AND DIVERSION APPLICANTS

An applicant with an active Adult Protective Services (APS) case is given priority when critical needs can be addressed by MI Choice services. It is not expected that MI Choice waiver agencies solicit APS cases, but priority is given when necessary.

An applicant is eligible for diversion priority if they are living in the community or are being released from an acute care setting and are found to be at imminent risk of nursing facility admission. Imminent risk of placement in a nursing facility is determined using the Imminent Risk Assessment (IRA), an evaluation developed by MDCH. Use of the IRA is essential in providing an objective differentiation between those applicants at risk of a nursing facility placement and those at imminent risk of such a placement. Only applicants found to meet the standard of imminent risk are given priority status on the waiting list. Applicants may request that a subsequent IRA be performed upon a change of condition or circumstance.

Supports coordinators must administer the IRA in person. The design of the tool makes telephone contact insufficient to make a valid determination. Waiver agencies must submit a request for diversion status for an applicant to MDCH. A final approval of a diversion request is made by MDCH.

3.4.A.4. CHRONOLOGICAL ORDER BY SERVICE REQUEST DATE

This category includes applicants who do not meet any of the above priority categories or for whom prioritizing information is not known. As stated, participants will be placed on the waiting list in the chronological order that they requested services as documented by the date of TIG completion or initial nursing facility interview.

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Waiver agencies are required to conduct follow-up phone calls to all individuals on their waiting list. The calls are to determine the individual's status, offer assistance in accessing alternative services, identify individuals who should be removed from the list, and identify individuals who might be in crisis or at imminent risk of admission to a nursing facility. Each person on the waiting list is to be contacted at least once every 90 days. Persons in crisis or at risk require more frequent contacts. Each waiver agency is required to maintain a record of these follow-up contacts.

3.5. ENROLLMENT SLOTS

CMS approves a given number of enrollment slots for the MI Choice program in the waiver application process. A slot consists of the enrollment of an individual for the duration of the fiscal year or in other words, the total number of slots used is an unduplicated count of participants for the fiscal year. Therefore, a participant who might be enrolled and removed from MI Choice numerous times throughout a given fiscal year utilizes only a single slot. Similarly, a person might be removed from the program at any given time, yet continues to occupy a slot until the conclusion of the fiscal year. It is an important distinction between that which constitutes enrollment and what is counted as a slot. Having a slot does not infer current enrollment.

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SECTION 4 - SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the most current assessment,
- detailed in the plan of service, and
- provided in accordance with the provisions of the approved waiver.

Services may not be provided unless they are defined in the plan of service and may not precede the establishment of a plan of service. Waiver agencies may neither limit in aggregate the number of participants receiving a given service nor the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider.

MDCH and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDCH and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider, thereby assuring freedom of choice.

4.1. COVERED WAIVER SERVICES

In addition to regular State Plan coverage, MI Choice participants may receive services that include:

4.1.A. ADULT DAY HEALTH

Adult Day Health services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., 3 meals per day. Physical, occupational and speech therapies are furnished as component parts of this service. Transportation between the participant's place of residence and the Adult Day Health center is provided when it is a standard component of the service.

4.1.B. HOMEMAKER

Homemaker services include the performance of general household tasks (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker when the individual regularly responsible for these activities, i.e., the participant or an informal supports provider, is temporarily absent or unable to manage the home and upkeep for himself or herself. Each provider of Homemaker services must observe and report any change in the participant's condition or of the home environment to the supports coordinator.

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4.1.C. PERSONAL CARE

Personal Care services encompass a range of assistance to enable program participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Personal Care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law.

Services provided through the waiver differ in scope, nature, supervision arrangement, or provider type (including provider training and qualifications) from Personal Care services in the State Plan. The chief differences between waiver coverage and State Plan services are those services that relate to provider qualifications and training requirements, which are more stringent for personal care provided under the waiver than those provided under the State Plan.

Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. These services may also include assistance with more complex life activities. The service may include the preparation of meals but does not include the cost of the meals themselves. When specified in the plan of service, services may also include such housekeeping chores as bed making, dusting, and vacuuming that are incidental to the service furnished or that are essential to the health and welfare of the participant rather than the participant's family. Personal Care may be furnished outside the participant's home.

4.1.D. RESPITE CARE

Respite Care services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those persons normally providing care for the participant. Services may be provided in the participant's home, in the home of another, or in a Medicaid-certified hospital or a licensed Adult Foster Care. Respite care does not include the cost of room and board, except when provided as part of respite care furnished in a facility approved by MDCH that is not a private residence.

Services include:

- Attendant Care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation.
- Basic Care (participant may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

There is a 30-days-per-calendar-year limit on respite services provided outside the home.

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4.1.E. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable participants 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 or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items.

This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's plan of service.

All items shall meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregivers in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.

4.1.F. FISCAL INTERMEDIARY

Fiscal Intermediary Services assist participants in self-determination in acquiring and maintaining services defined in the participant's plan of service, controlling a participant's budget, and choosing staff authorized by the waiver agency. The Fiscal Intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the individual's plan of service. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the individual (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant-directed budget expenditures and identifying potential over and under expenditures, and assuring compliance with documentation requirements related to management of public funds. The Fiscal Intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications including reference and background checks and assisting the participant to understand billing and documentation requirements.

Fiscal Intermediary Services are available only to participants choosing the self-determination option.

4.1.G. GOODS AND SERVICES

Goods and Services are services, equipment or supplies not otherwise provided through MI Choice or through the Medicaid State Plan that address an identified need in the individual plan of service (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements. The item or service would:

- decrease the need for other Medicaid services,
- promote inclusion in the community,
- increase the participant's safety in the home environment, and
- these goods and services are only available if the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Goods and Services are only approved by CMS for self-direction participants. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the individual's plan of services.

4.1.H. CHORE SERVICES

Chore Services are 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, and moving heavy items of furniture in order to provide safe access and egress. This service also includes yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or 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.

4.1.I. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) services facilitate an individual's independence and promote reasonable participation in the community. Services can be provided in the participant's residence or in a community setting to meet support and service needs.

CLS may include assisting, reminding, cueing, observing, guiding, or training with meal preparation, laundry, household care and maintenance, shopping for food and other necessities, and activities of daily living such as bathing, eating, dressing, or personal hygiene. It may provide assistance with such activities as money management, non-medical care (not requiring nurse or physician intervention), social participation, relationship maintenance and building community connections to reduce personal isolation, non-medical transportation from the participant's residence to community activities, participation in regular community activities incidental to meeting the individual's community living preferences, attendance at medical appointments, and acquiring or procuring goods and services necessary for home and community living.

CLS staff may provide other assistance necessary to preserve the health and safety of the individual so they may reside and be supported in the most integrated independent community setting.

CLS services cannot be authorized in circumstances where there would be a duplication of services available elsewhere or under the State Plan. CLS services may not be authorized in lieu of, as a duplication of, or as a supplement to similar authorized waiver services. The distinction must be apparent by unique hours and units in the individual's plan of service. Tasks that address personal care needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care service in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.

When transportation incidental to the provision of CLS is included, it must not also be authorized as a separate waiver service. Transportation to medical appointments is covered by Medicaid through the State Plan.

Community Living Supports do not include the cost associated with room and board.

4.1.J. COUNSELING

Counseling services seek to improve the individual's emotional and social well being through the resolution of personal problems or with changes in an individual's social situation.

Counseling services must be directed to waiver participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the waiver participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term mental health needs.

4.1.K. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home, required by the participant's plan of service, that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are not of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit unless necessary to complete an adaptation.

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4.1.L. HOME DELIVERED MEALS

Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for his/her own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Counsel of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets, as indicated in the participant's plan of service. A Home Delivered Meal cannot constitute a full nutritional regimen.

4.1.M. NON-MEDICAL TRANSPORTATION

Transportation services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the participant's plan of service. Whenever possible, family, neighbors, friends, or community agencies that can provide transportation services without charge must be utilized before MI Choice may provide transportation services.

MI Choice transportation services are 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), and does not replace them. MI Choice transportation services may not be substituted for the transportation services that MDCH is obligated to provide under the listed citations. Such transportation, when provided for medical purposes, is not reimbursable through MI Choice. When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health), there must be mechanisms to prevent the duplicative billing of Non-Medical Transportation services.

4.1.N. NURSING FACILITY TRANSITION SERVICES

Nursing Facility Transition (NFT) services are non-recurrent expenses for persons transitioning from a nursing facility to a community setting. Allowable transition costs include the following:

- Housing or security deposits: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are not included).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are not included).
- Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.
- Coordination and support services: To facilitate transitioning of participant to a community setting.
- Other: Services deemed necessary and documented within the participant's plan of service to accomplish the transition into a community setting. NFT services do not include monthly

housing rental or mortgage expense, food, or regular utility charges. Costs for NFT services are billable upon enrollment into the MI Choice program.

4.1.O. PERSONAL EMERGENCY RESPONSE SYSTEM

A Personal Emergency Response System (PERS) is an electronic device that enables a waiver participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided. PERS does not cover monthly telephone charges associated with phone service.

4.1.P. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) consists of individual and continuous nursing care (in contrast to "Skilled Nursing" services characterized by part-time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home. MI Choice participants 18-21 years-old who meet the eligibility requirements for Medicaid State Plan PDN services will continue to receive PDN services through the Medicaid State Plan and will not receive PDN services through MI Choice. Older MI Choice participants may continue to receive PDN services as a MI Choice service.

Participants receiving PDN services must remain on active status when determining re-assessment schedules. Refer to the Reassessment of Participants subsection of this chapter for additional information. PDN services may not be used in place of, or as a substitute for, other waiver or State Plan services.

4.1.Q. RESIDENTIAL SERVICES

MI Choice participants who receive Residential Services must reside in a home-like, non-institutional setting licensed by the State of Michigan. As a stipulation of the licensure standards, such settings provide continuous on-site response capability to meet scheduled or unpredicted resident needs and provide supervision, safety, and security. Residential Services include enhanced assistance with activities of daily living and supportive services that rise above the level of service mandated by licensing requirements. Residential services are intended to supplement the existing level of services provided in licensed settings, particularly labor intensive activities, which are above the scope of service normally provided. Residential services are authorized to prevent the institutionalization of the participant.

Additional assistance can include assisting, reminding, cueing, observing, guiding or training in activities of daily living (such as bathing, eating, dressing, or personal hygiene), assistance, support or guidance with such activities as non-medical care (not requiring nurse or physician intervention), special homemaking needs, social participation, relationship maintenance and building community connections to reduce personal isolation, participation in regular community activities incidental to meeting the individual's community living preferences, attendance at medical appointments, and staff

assistance with preserving the health and safety of the individual in order that they may reside and be supported in the most integrated independent community setting.

Third parties may only provide Residential Services with the approval of the participant, licensee, and waiver agency. Payment for Residential Services excludes room and board costs, items of comfort and convenience, costs of facility maintenance, upkeep, and improvement, or other costs that are required as a term of licensure. Residential Service providers are limited to billing under a discrete set of Healthcare Common Procedure Coding System (HCPCS) codes for their services.

Residential Services cannot be provided in circumstances in which they would duplicate services available elsewhere or are available under the State Plan. The distinction must be apparent by unique hours and units in the approved service plan.

4.1.R. TRAINING

Training services consist of instruction provided to a MI Choice participant or caregiver in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's plan of service. Training is covered for areas such as activities of daily living, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, Training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision or other areas related to self-direction.

4.2. STATE PLAN SERVICES

MI Choice services are designed to address the unique needs and circumstances of the program participants. Some waiver services might appear to be the same as services offered in the State Plan; however, they differ in terms of key elements, such as scope of coverage or provider qualifications. Inasmuch as waiver services are designed to meet the specific demands of the waiver participants, it is expected that a waiver service will be more appropriate for a waiver participant than a similar State Plan service. Under no circumstances shall the participant receive both services. Waiver agencies cannot authorize payment for services that are offered under the State Plan.

4.3. HOSPICE

MI Choice participants may receive State Plan-covered hospice services while participating in MI Choice. Participants must meet all hospice eligibility requirements outlined in the Hospice Chapter.

State Plan Hospice services must be used to the fullest extent before similar MI Choice services are authorized. Inappropriate services (e.g., duplicative, non-covered) are subject to MDCH recovery of the amounts paid for those services from the waiver agency.

MI CHOICE WAIVER

A joint plan of service for Hospice and MI Choice must be developed and maintained by both the waiver agency and the hospice provider. It is important that the waiver agency understand the hospice philosophy so the two entities work for a common goal and avoid redundant services. Ongoing communication and coordination must occur between the MI Choice supports coordinator and the hospice provider during the time they are serving the participant. Written documentation of this communication and coordination must be kept in the participant record at each agency.

4.4. MEDICATION ASSISTANCE

Medication assistance in MI Choice is established through the provisions of the Private Duty Nursing service.

4.5. OPERATING STANDARDS

MDCH maintains and publishes the "Minimum Operating Standards for MI Choice Waiver Program Services" (known as the Minimum Operating Standards) document. This document defines both general and specific operating criteria for the program. All waiver agencies and service providers are subject to the standards, definitions, limits, and procedures described therein.

For each service offered in MI Choice, the Operating Standards are used to set the minimum qualifications for all direct service providers, including required certifications, training, experience, supervision, and applicable service requirements. Billing codes and units are also defined in the document.

4.6. SERVICES IN LICENSED SETTINGS

Licensing rules for residential providers reflect an attempt to make residing in these settings much like it would be in a home. The rules address such issues as opportunities for the growth and development, participation in everyday living activities (including participation in shopping and cooking), involvement in education and employment, developing social skills, contact with friends and relatives, participation in community-based activities, privacy and leisure time, religious education and attendance at religious services, access to transportation, the right to exercise constitutional rights, the right to send and receive uncensored and unopened mail, reasonable access to telephone usage for private communication, the right to have private communications, participation in activities and community groups at the participant's discretion, the right to refuse treatment services, the right to relocate to another living situation, the right to be treated with consideration and respect, recognition of personal dignity and individuality, the need for privacy, the right to access participant’s room at their discretion, protections from mistreatment, access to health care, opportunity for daily bathing, three regular nutritious meals daily, the right to be as independent as the individual may so choose, the right to a clean and sanitary environment, adequate personal living space exclusive of common areas, adequate bathroom and facilities for the number of occupants, standard home-like furnishings, and the right to make their own decisions.

MI CHOICE WAIVER

SECTION 5 - NURSING FACILITY TRANSITIONS

The process of transitioning applicants residing in a nursing facility to a home or a community-based setting is a priority of MI Choice. The tenet of rebalancing the spectrum of long-term care services in Michigan was given impetus by the 1999 United States Supreme Court decision in Olmstead v. L. C.. MDCH provides mechanisms to ensure an individual resides in the most appropriate setting.

5.1. TRANSITION CANDIDATES

Initial transition work begins prior to the applicant's enrollment into the MI Choice program and often occurs before the verification of his/her Medicaid eligibility. NFT service candidates are individuals who have resided in a nursing facility for an extended period of time, have not been admitted to the nursing facility for a rehabilitation stay or other temporary, short-term admission, have expressed a preference to live at home or in a community-based setting, have transition needs that exceed the capacity of the nursing facility discharge planning process, and are likely to meet MI Choice eligibility requirements.

5.2. TRANSITION SERVICES

Transition services are one-time expenses necessary to assist an individual moving from a nursing facility to a home or similar community setting. Examples of transition services that the waiver agency could provide are in the Nursing Facility Transition services subsection of this chapter.

NFT services are not intended to provide assistance for persons relocating from communal settings such as, but not limited to, adult foster care (AFC) homes, Homes for the Aged (HFAs), assisted living arrangements, or apartments to another home or home-like setting.

The MI Choice waiver agency must work with the applicant to develop a transition plan that includes all projected transition costs (not including supports coordination). The plan must be based on individual goals and needs and must be included in the applicant's MI Choice record. It must be updated to reflect any changes.

MDCH will reimburse waiver agencies for transition-related expenses for a period not to exceed a six-months. In addition, MDCH will reimburse allowable transition expenses incurred over the same six-month period for applicants who intend to transfer into the MI Choice program. MDCH must pre-approve any transition plans projected to total more than $3,000, which includes transition and supports coordination costs. No payments will be made to the MI Choice agency for Nursing Facility Transition services until the applicant is enrolled into the MI Choice program.

The MI Choice waiver agency must notify MDCH of its intention to transition a nursing facility resident to the MI Choice program when initiating a nursing facility transition plan. Procedures for notification are obtained from the MI Choice program contract manager.

MI CHOICE WAIVER

SECTION 6 - SUPPORTS COORDINATION

Supports coordination facilitates access to, and arrangement of, services and support needed and chosen by MI Choice participants. These are detailed and documented in the participant's plan of service. Functions of the supports coordinator include, but are not limited to:

- Assessment of the participant
- Development of the plan of service
- Service access
- Follow-up and monitoring of the participant
- Reassessment of the participant
- Social emotional support
- Advocacy for the participant

Supports coordinators use a person-centered approach in working with a participant to determine how his/her needs will be met. Supports coordinators also monitor the quality of services received and explore other funding options and service opportunities when personal goals exceed the scope of available MI Choice services. For participants choosing to self-determine his/her MI Choice options, the supports coordinator assists in the selection, coordination, and management of those services and providers.

MDCH includes a Supports Coordination Service Performance Standards document as an attachment to all waiver agency provider contracts. The document prescribes acceptable standards and protocols for the provision of supports coordination services. It is reviewed and amended as necessary.

6.1. PERSON-CENTERED PLANNING

Person-centered planning (PCP) is a process for planning services and supports with, and supporting, the participant that builds upon the participant's capacity to engage in lawful activities that promote community life and that honor the participant's preferences, choices, and abilities. Waiver agencies and direct service providers must utilize a PCP process, informing the participant of service options in ways that are meaningful. This includes assessing the needs and desires of the participant, developing service and support plans, and continuously updating and revising those plans as needs and desires change. The participant and his/her chosen representative(s) must be provided with written information from the waiver agency detailing the right to participate in the PCP process. Waiver agencies and direct service providers implement PCP in accordance with the MDCH Person-Centered Planning Guideline document that is an attachment to the waiver agency provider contract.

PCP meetings are conducted when the participant is not in crisis and at a time of the participant's choice. The participant has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process. An interim plan of service may be developed by the supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the participant is not ready to fully participate in PCP. Interim care plans are authorized for no more than 30 days without a follow-up re-assessment to determine the participant's status.

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6.2. PLAN OF SERVICE

The participant's plan of service is an individualized, comprehensive document developed by the participant, his/her chosen representative(s), and the supports coordinator prior to the provision of services. Using a person-centered process, waiver agencies must establish a written plan of service for each participant that identifies the individual's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. This document includes all services provided to, or needed by, the participant and is developed before services are provided, regardless of funding source. The participant must approve all services and interventions before implementation and the waiver agency must document participant approval. MI Choice services must be stipulated in the PCP planning process and the participant assessment.

The participant's plan of service contains at a minimum:

- Issues, problems and concerns identified during participant (re)assessment
- Goals for each issue, problem and concern or reason for omission from the plan
- Planned interventions for each goal
- Desired outcome for each intervention
- Participant's agreement to the plan
- A process for reviewing progress and outcomes

The participant's plan of service contains, at a minimum:

- The type of service(s) to be provided, including both MI Choice services and from other sources
- The frequency and duration of each service
- The type of provider to furnish each service

6.3. SELF-DETERMINATION

Self-Determination provides MI Choice participants the option to direct and control his/her own waiver services. Not all MI Choice participants choose to participate in self-determination. For those that do, the participant (or chosen representative(s)) has decision-making authority over workers who provide waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring (co-employer)
- Selecting staff from worker registry
- Hiring staff (common law employer)
- Verifying staff qualifications
- Obtaining criminal history and background investigation of staff
- Specifying additional service or staff qualifications based on the participant's needs and preferences so long as such qualifications are consistent with the qualifications specified in the approved waiver application and the Minimum Operating Standards

- Specifying how services are provided and determining staff duties consistent with the service specifications in the approved waiver application and the Minimum Operating Standards
- Determining staff wages and benefits, subject to State limits (if any)
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff (common law employer)
- Discharging staff from providing services (co-employer)
- Reallocating funds among services included in the participant's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Authorizing payment for Goods and Services
- Reviewing and approving provider invoices for services rendered

Participant budget development for participants in self-direction occurs during the person-centered planning process and is intended to involve individuals the participant chooses. Planning for the participant's plan of service precedes the development of the participant's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. An participant's budget is not authorized until both the participant and the waiver agency have agreed to the amount and its use. In the event that the participant is not satisfied with the authorized budget, he/she may reconvene the person-centered planning process. The waiver services of Fiscal Intermediary and Goods and Services are available specifically to self-determination participants to enhance their abilities to more fully exercise control over their services.

The participant may, at any time, modify or terminate the arrangements that support self-determination. The most effective method for making changes is the person-centered planning process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may be interfering with the success of a self-determination arrangement. The decision of a participant to terminate participation in self-determination does not alter the services and supports identified in the participant's plan of service. When the terminate participation, the waiver agency has an obligation to assume responsibility for assuring the provision of those services through its network of contracted provider agencies.

A waiver agency may terminate self-determination for a participant when problems arise due to the participant's inability to effectively direct services and supports. Prior to terminating a self-determination agreement (unless it is not feasible), the waiver agency informs the participant in writing of the issues that have led to the decision to terminate the arrangement and continues trying to resolve the issues that led to the termination.

MI CHOICE WAIVER

SECTION 7 - ADMINISTRATION

MDCH serves as the single state agency in the operation of the MI Choice program. MDCH contracts with entities to administer the program throughout the state. Certain administrative functions are assigned to the local agencies as defined in the Medicaid waiver application to CMS, as renewed and amended. To assist MDCH in operating MI Choice, agencies are required to submit periodic reports as detailed in this section.

7.1. WAIVER AGENCIES AS ORGANIZED HEALTH CARE DELIVERY SYSTEMS

MDCH contracts with waiver agencies who operate as Organized Health Care Delivery Systems (OHCDS) to perform administrative and supports coordination functions. They are responsible for disseminating waiver information to applicants, assisting applicants with waiver enrollment (which includes assisting applicants with completion of the Medicaid eligibility application document DHS-1171 to secure financial eligibility), managing waiver enrollment against approved limits, monitoring expenditures against approved limits, conducting assessments and LOCD evaluations, reviewing participant plans of service to ensure that waiver requirements are met, conducting utilization reviews and quality management reviews, recruiting providers, and executing Medicaid provider agreements.

Each waiver agency must sign a provider contract with MDCH assuring that it meets all program requirements. In addition, each waiver agency must directly provide at least one waiver service.

Waiver agencies are responsible for securing qualified service providers to deliver services. Eligible provider applicants include public, private non-profit or for-profit organizations that provide services meeting established service standards, certifications or licensure requirements.

7.2. WAITING LIST REPORTING

Each waiver agency is required to submit data to MDCH detailing information about persons on its waiting list during the fiscal quarter. The waiting list data must be submitted to MSA at michoicewaitinglist@michigan.gov no later than the 15th of the month following the end of the MDCH quarter as identified below:

Data Collection	Period	Due Date
First Quarter	October 1 – December 31	January 15
Second Quarter	January 1 – March 31	April 15
Third Quarter	April 1 – June 30	July 15
Fourth Quarter	July 1 – September 30	October 15

The data must be submitted in the order listed in the MI Choice Waiting List Data Collection form. This required waiting list template can be requested by contacting the Medical Services Administration (MSA). Refer to the Directory Appendix for contact information.

Each quarterly submission should list only those applicants who were on the waiting list during any portion of the reporting period. Participants who were enrolled in the waiver or who were otherwise removed from the waiting list prior to the first date of the quarter should not be included on the list.

Applicants who are added to the waiting list after the conclusion of the fiscal quarter being accounted for should not be listed until the following quarter.

Each person on the waiting list should have a single record on the file. If a waiver agency's database has multiple entries for the same person due to different addresses, contacts, etc., include only the most recent information.

All data must be transmitted in a secure fashion as they contain protected personal health information. If a waiver agency cannot submit information by encrypted e-mail or secure file exchange, another acceptable option is to copy the file to a compact disc (CD) and mail it to the MDCH Long Term Care Program Policy staff. Refer to the Directory Appendix for contact information. Hard copy printouts of data records will not be accepted.

7.3. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

All MI Choice waiver agencies and providers are required to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any subsequent revisions. Compliance is required in areas that include privacy and security rules, data sharing, and disclosure.

MI CHOICE WAIVER

SECTION 8 - FINANCING AND REIMBURSEMENT

Annual funding levels for MI Choice are subject to appropriation allocations made by the Michigan Legislature. MDCH contracts annually with waiver agencies to operate the MI Choice program and all waiver agency budget and reimbursement requirements and considerations must be defined in the contract, as amended. Any additional consideration or compensation to the waiver agency must also be included in the annual contract, as amended. Waiver agencies are required to submit all claim data to MDCH as outlined in the Claims Reporting subsection of this chapter. Claims data is processed through the Community Health Automated Medicaid Processing System (CHAMPS). Waiver agencies are required to submit all financial reports as detailed in the annual contract. MDCH will reconcile all payments made to each waiver agency with the properly reported and approved claims following the conclusion of each fiscal year. Each agency is subject to review or audit by MDCH, the State of Michigan, or their designee.

8.1. SUPPORTS COORDINATION AND OPERATIONS REIMBURSEMENT (SCORE)

Reimbursing waiver agency administrative cost is done through a formula known as the Supports Coordination and Operations Reimbursement (SCORE). The model recognizes the two main functions of agency administration, specifically the roles of supports coordination and waiver operation.

The reimbursement model calculates reimbursement amounts for supports coordination separately from other administrative activities. The base administrative reimbursement is a regression of historical administrative costs on the relative size of the agency as determined by the amount of waiver services provided during the calculation period. The base supports coordination amount is determined by the number of participant months during the period weighted by the relative Resource Utilization Group (RUG) category and multiplied by an average cost amount. This acuity-based determination of reimbursement for supports coordination may then be adjusted for performance measures deemed important by MDCH.

SCORE amounts are recalculated annually in conjunction with the agency contracting cycle. The calculation is based on the most current robust claims data available. Agency data that has not been submitted in accordance with policy is not considered when evaluating the completeness of data for the calculation. Agency appeals of the SCORE calculation are addressed through the contracting process.

8.2. REIMBURSEMENT SCHEDULE

Waiver agencies will be given monthly prospective payments based on MDCH's formula to determine the agency's annual budget allocation. The monthly payment may be adjusted based on claims information submitted in the agency's monthly Financial Status Report, on a change in the status of the MI Choice appropriation amount, or on any other basis approved by MDCH.

Each agency will be subject to a cost reconciliation process following the conclusion of each fiscal year subject to the provisions contained the Closing and Cost Reconciliation subsection of this chapter.

8.3. SPECIAL FINANCING

MDCH may arrange special financing structures that extend beyond the standard contract language to address special circumstances that might arise. Any such arrangement must be approved in advance by MDCH and must be clearly defined in the waiver agency contract.

MI CHOICE WAIVER

8.3.A. EXCEPTIONAL CARE NEEDS

MDCH recognizes that the care needs of some participants are exceptional in comparison with the general MI Choice population. Rather than omit such participants from the program, MDCH provides waiver agencies extra consideration in allowing the waiver agencies to authorize the necessary services and support for such individuals.

A Memorandum of Understanding (MOU) for participants with extensive service and support needs may be requested for participants whose average daily service costs meet or exceed $120.00 for a seven-day service week regardless of how many days the participant actually received services. MDCH will not approve an MOU request to cover short-term increases in service costs due to temporary increases in MI Choice services. MDCH defines short-term as less than 30 days.

MDCH will authorize a Special Memorandum of Understanding (SMOU) for participants with complex medical acuity who require extensive MI Choice services. MDCH will consider an SMOU for participants meeting at least one of the following:

- Participant is aging out of the Children's Special Health Care Services program or transferring from the Habilitation Supports Waiver program who requires continuing private duty nursing services
- Participant is ventilator dependent
- Participant has a tracheotomy that requires extensive suctioning, tracheotomy care, or nebulizer treatments
- Participant has multiple wounds at stages 2, 3, or 4 that require frequent dressing changes and treatment
- Participant has a medical condition with a high acuity and the attendant required care is complex (i.e., a combination of tube feedings, dressing changes, intravenous medications, oxygen therapy, colostomy/ileostomy, etc.)

MDCH will not approve an SMOU for participants for the following:

- Participant requires a temporary increase in services to either provide relief for, or substitute for, informal support
- Participant requires a temporary increase in services to cover night, weekend, or holiday premiums for staff

The waiver agency may apply for an SMOU through procedures stipulated in Appendix C of the waiver agency contract. MDCH approves SMOU requests for up to one year.

Waiver agencies must receive MDCH approval for these enhanced service.

8.3.B. PRIORITY AND TARGETED POPULATIONS

At its discretion, MDCH may make special financing arrangements available to facilitate, encourage, or otherwise enable enrollment for priority or targeted populations. All such

arrangements must comply with provisions of the waiver. Any rules specific to these arrangements will be defined by MDCH and must be approved by CMS.

8.3.C. GAP SERVICES

Waiver agencies may authorize services for waiver participants to address situations that require immediate attention to alleviate barriers crucial to the participant's independence when no other resources, including waiver services, are available to address such needs. These are referred to as gap-filling services and are to be included in the participant's plan of service.

Gap-filling services are not eligible for federal financial participation (FFP) and so claims cannot be processed through CHAMPS.

8.3.D. TIP SERVICES

Waiver agencies may authorize services for temporarily ineligible participants (TIP). TIP services are necessary to sustain a participant though a temporary period of ineligibility. TIP services are included in the participant's plan of service and the reason such services are necessary must be documented by the waiver agencies.

TIP services are not eligible for federal financial participation (FFP) and so claims cannot be processed through CHAMPS. TIP services for any given participant are limited to a cumulative total of no more than 90 days per calendar year unless prior approval is obtained from MDCH.

8.3.E. LOCAL FUNDING ENHANCEMENT

Waiver agencies may solicit and forward to MDCH funds from local sources that can be used to enhance the provision of MI Choice services for participants in their service respective service areas. This enhanced funding shall be expended in accordance with the approved waiver application.

Enhanced funding may not be used to provide MI Choice services to any designated geographic or demographic sub-population in the service area. Participants receiving services under enhanced funding arrangements must meet all MI Choice eligibility requirements. Services provided by such funding are approved waiver services and adhere to all established rules and qualifications of the MI Choice program.

8.4. CLAIMS REPORTING

Medicaid is established as the payer of last resort. Waiver agencies must pursue and secure all third party liability (TPL) sources possible. Agencies must make every effort to enroll and utilize dually certified (Medicare and Medicaid) providers. Agencies cannot bill claims to the MI Choice program that are covered through another payment source.

Each waiver agency must submit all claims data to MDCH within 180 calendar days of the date that services were rendered. Waiver agencies must resolve issues related to claims that are rejected by CHAMPS within 30 calendar days of notification by MDCH or its designee. The agencies have ten (10)

calendars days after the expiration of the 30-day resolution window to report on issues that cannot be resolved.

8.5. FINANCIAL REPORTING

Each waiver agency shall submit a Financial Status Report (FSR) through the Electronic Grants Administration and Management System (EGrAMS) operated online by the State of Michigan. MDCH contacts each waiver agency with instructions on how to find and access the EGrAMS system. Each FSR shall cover one calendar month and is due within 30 calendar days after the conclusion of that month.

Waiver agencies must submit additional financial reports and information as requested by MDCH. MDCH must communicate requirements for such additional information to the waiver agency in writing and allow sufficient time for a response.

8.6. CLOSING AND COST RECONCILIATION

All prospective payments are to be reconciled against demonstrated actual costs and utilization. MDCH will prepare an initial reconciliation within 180 calendar days from the end of the fiscal period based on cost and utilization data submitted to the CHAMPS system. Waiver agencies have 30 calendar days to review the initial reconciliation, input additional or missing data into CHAMPS, submit additional documentation to MDCH, or request changes or clarification from MDCH. A final reconciliation shall be computed within 90 calendar days from the mailing of the initial settlement. Waiver agencies shall have 30 calendar days from the date of the final reconciliation letter to accept or appeal the final reconciliation determination. MDCH shall initiate recovery procedures if no response is received in the designated timeframes. All claims data must be entered into CHAMPS to be considered in the reconciliation.

8.7. FINANCIAL AUDIT REQUIREMENTS

MI Choice waiver agencies are contractually obligated to comply with, and assure compliance by, its subcontractors with all requirements of the Single Audit Act and any amendments to this act. Waiver agencies must submit to MDCH a Single Audit, Financial Statement Audit, or Audit Status Notification Letter. If submitting a Single Audit or Financial Statement Audit, waiver agencies must also submit a Corrective Action Plan for any audit findings that impact MDCH-funded programs and a management letter (if issued) with a response.

Waiver agencies that expend $500,000 or more in federal awards during the agency's fiscal year must submit to MDCH a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" (as revised).

Waiver agencies exempt from the Single Audit requirements that receive $500,000 or more in total funding from MDCH in state and federal grant funding must submit to MDCH a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS). Waiver agencies exempt from the Single Audit requirements that receive less than $500,000 of total MDCH grant funding must submit to MDCH a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that negatively impact MDCH-funded programs including, but not limited to, fraud, financial statement misstatements, and violations of contract and grant provisions.

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Waiver agencies exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template for the Audit Status Notification Letter and further instructions are available on the MDCH website. Refer to the Directory Appendix for website information.

The required audit and any other required submissions (i.e. Corrective Action Plan and management letter with a response) or Audit Status Notification Letter must be submitted within nine months following the end of the contractor's fiscal year to: Michigan Department of Community Health, Office of Audit, Quality Assurance and Review Section.

Waiver agencies and each of their contractors are subject to the provisions of, and must comply with, the cost principles set forth in OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments (as revised).

MI CHOICE WAIVER

SECTION 9 - PROVIDERS

Authorization for provision of services is the responsibility of the waiver agencies. They determine the status of the qualifications and certifications (if applicable) for all direct service providers, negotiate and enter into contracts with the providers, and reimburse providers.

It is possible for a provider to subcontract with, and be reimbursed directly by, MDCH. The circumstances necessitating such an arrangement must be determined on a case-by-case basis by MDCH.

9.1. ENROLLMENT OF SERVICE PROVIDERS

Waiver agencies must use written contracts meeting the requirements of 42 CFR 434.6 to deliver services. Entities or individuals under subcontract with the waiver agencies must meet provider standards defined in the Minimum Operating Standards for MI Choice Waiver Program Services which is maintained by MDCH and attached to each annual waiver agency contract. Providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

9.2. FAMILY MEMBERS AS SERVICE PROVIDERS

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify his/her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the plan of service and authorized by the supports coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the plan of service, the supports coordinator may rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

9.3. REIMBURSEMENT RATES

Each waiver agency is responsible for sub-contracting with provider entities and for assuring access to services. The process of rate determination resides in the contract negotiation between the waiver agency and the provider. MDCH does not play a role in this process. Per Michigan law, MDCH is prohibited from setting fee screens or setting rates for waiver services.

Rates paid for services provided through the waiver must be adequate to assure access to services needed by waiver participants.

MDCH does not make payment to legally responsible individuals for furnishing personal care or similar services.

MDCH does not reimburse for the rent and food expenses of any caregiver who resides in the same household as the participant.

MI CHOICE WAIVER

9.4. BACKGROUND CHECKS

Each waiver agency and direct provider of home-based services must conduct a criminal background review through the Michigan State Police for each paid staff person or volunteer who will be entering a participant's residence. The waiver agency and direct provider shall have completed reference and background checks before authorizing an employee or volunteer to furnish services in a participant's residence. The scope of the investigation is statewide.

Both waiver agencies and MDCH conduct administrative monitoring reviews of providers annually to verify that mandatory criminal background checks have been conducted in compliance with operating standards.

9.5. USE OF RESTRAINTS

Providers are prohibited from using restraints. Registered Nurse Reviewers (RNRs) in the process of conducting Clinical Quality Assurance Reviews and home visits shall use a discovery process to examine the use of restraints by family or caregivers.

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SECTION 10 – PROGRAM QUALITY

The process of ensuring the highest quality program involves a continuous cycle of discovery, intervention, and evaluation. MDCH is resolute about assuring and improving the quality of services and protections it provides. To assure that level of service, MDCH operates a comprehensive quality management system that incorporates reviews of the administrative operations of the waiver agencies, clinical reviews of the agency services, home reviews with individual participants, continuous quality management and planning of, and timely and effective responses to critical incidents.

10.1. ADMINISTRATIVE QUALITY ASSURANCE REVIEWS

MDCH develops a MI Choice Waiver Program Provider Monitoring Plan (known as the Monitoring Plan) to which each waiver agency shall adhere. The document defines the procedures and standards used by MDCH in reviewing agencies and providers. It describes the required protocols to identify programmatic deficiencies and timelines for remediation.

MDCH conducts periodic on-site Administrative Quality Assurance Reviews (AQAR) of each waiver agency on a schedule defined in the Monitoring Plan. Each waiver agency must be reviewed at least once every two fiscal years. MDCH seeks evidence of compliance to the AQAR standards during the on-site review through examination of waiver agency policies and procedures, provider contracts, financial systems, claims accuracy, and quality management plans.

MDCH informs each waiver agency of deficiencies that require corrective action and provides a date for the waiver agency to demonstrate compliance. In the event of a continued deficiency, MDCH has the authority to take action towards the waiver agency which may include suspending new enrollments, adjusting payments, or mandating further corrective action. MDCH has the option to suspend or terminate the contract of any waiver agency that fails to correct stated deficiencies noted on a second review.

10.2. QUALITY MANAGEMENT PLANS

Each waiver agency shall have a written quality management plan that meets requirements specified in the CMS Interim Procedural Guidance (February 6, 2007) and the MDCH Quality Management Plan as amended. The quality management plan addresses quality assurance and improvement using measurable goals and quality performance indicators.

MDCH reviews quality management plans annually. Waiver agencies are required to submit an annual report to MDCH highlighting its quality management plan activities and improvements.

10.3. CLINICAL QUALITY ASSURANCE REVIEWS

MDCH conducts an annual Clinical Quality Assurance Review (CQAR) of each waiver agency. The review is to determine whether the authorized services in the plan of service are sufficient to protect the health and welfare of the participant.

Randomly selected records are reviewed. Samples are derived using federally-approved sampling techniques with a minimum of 10 records reviewed at each agency. In addition, 10 home visits are conducted to verify information in the records. The review is to be conducted by a team of trained MDCH reviewers.

10.4. CRITICAL INCIDENT RESPONSE AND REPORTING

MI Choice is required to track and to report certain events that might indicate exceptional risk to the participant. Not only are these requirements defined in regulation, but in law as well.

10.4.A. TYPES OF CRITICAL INCIDENTS AND SERIOUS EVENTS

The following are specific critical incidents or events that must be reported to MDCH:

- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Neglect
- Physical abuse
- Provider no-shows, particularly when the participant is bed bound all day or there is a critical need the service to be provided
- Sexual abuse
- Theft
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Suspicious or Unexpected Death that is also reported to law enforcement and is related to providing services, supports, or care

10.4.B. CRITICAL INCIDENT RESPONSE

MI Choice waiver agencies have the initial responsibility for identifying, investigating, evaluating and responding to critical incidents that occur with participants as listed above. All suspected incidents of abuse, neglect and exploitation require reporting to the Department of Human Services, Adult Protective Services (DHS-APS) for investigation and follow-up. Agencies shall begin investigating and evaluating critical incidents within two business days of the date that it was noted that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDCH as soon as reasonably possible, i.e., within two business days.

Each waiver agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect or exploitation. The policies and procedures must include procedures for follow-up activities with DHS-APS to determine the result of the reported incident and the next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect or exploitation, as well as the referral to DHS-APS, must be maintained in the participant's case record.

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10.4.C. CRITICAL INCIDENT REPORTING

Waiver agencies are responsible for tracking and responding to each critical incident using the Critical Incident Management Report form. Waiver agencies are required to report the number of critical incidents recorded, responses to those incidents, and the outcome and resolution of each event. It is required that the waiver agencies submit individual critical incident reports and a 6-month summary report that are due to MDCH staff on January 15 and July 15 of each year.

All critical incident reports must include a description of each incident, investigations, strategies implemented to reduce, ameliorate and prevent future incidents from recurring, and follow-up activities conducted through the resolution of each incident.

MDCH must receive notification from waiver agencies of suspicious deaths within 48 hours of the event.

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SECTION 11 - APPEALS

The Michigan Department of Community Health has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E of the Code of Federal Regulations. Provider appeal rights conform to the requirements of Michigan law and rules found at MCL 400.1 et seq. and MAC R 400.3401 et seq.

11.1. PARTICIPANT APPEALS

MI Choice has established notice and appeals requirements to which waiver agencies must adhere when adverse action has been taken for program applicants and participants. According to 42 CFR 431.201 "Action" means a termination, suspension, or reduction of Medicaid eligibility or of covered services. This also includes determinations by the waiver agent that the applicant or participant does not meet the nursing facility level of care criteria and other denials of Medicaid eligibility or of covered services.

11.1.A. Adequate Action Notices

MI Choice waiver agencies must send an Adequate Action Notice to applicants or participants informing them of adverse actions and determinations taken under the following circumstances:

- when the waiver agency is at operating capacity and unable to enroll MI Choice applicants who request a Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- when the waiver agency determines applicants to be medically ineligible for MI Choice services based on the results of an in-person LOCD.
- when a participant requests additional services or additional amounts of services and the waiver agency denies the request
- when an existing benefit is reduced, suspended or terminated, and meets the requirements for an exception from an Advance Action Notice as specified in 42 CFR 431.213.

11.1.B. Advance Action Notices

An Advance Action Notice must be sent to MI Choice participants when action is being taken to reduce, suspend, or terminate service(s) a participant currently receives. This notice must be provided at least 12 days in advance of the intended action.

An Advance Action notice is also issued if it is determined that a reduction in level or number of services is warranted based on the participant's current assessment. The notice must inform the participant that services will not be reduced until a formal decision has been rendered through the Medicaid Fair Hearings process, if the participant formally requests a hearing before the specified date of the intended action.

11.1.C. NOTICES

Advanced Action Notices and Adequate Action Notices that relate to the LOCD process are posted on the MDCH web site. Refer to the Directory Appendix for website information.

Waiver agencies may use additional notices for actions not related to the LOCD process. These notices must be approved by MDCH prior to use to assure compliance with 42 CFR 431.210. Waiver agencies must supply a copy of the DCH-0092, Request for Hearing form, and a return envelope with each notice sent to an applicant or participant, or any time an applicant or participant requests such material. Waiver agencies are required to assist applicants or participants who request help in filing an LOCD exception review through the Michigan Peer Review Organization (MPRO), or a formal appeal for any reason through the Medicaid fair hearings process.

11.2. PROVIDER AND WAIVER AGENCY APPEALS

Medicaid providers, including waiver agencies, are afforded appeal rights under the Michigan Social Welfare Act (Public Act 280 of 1939, as amended) and the Michigan Administrative Code. Adverse actions that may be appealed by providers include, but are not limited to, the suspension or termination of participation in the Medicaid program, or a reduction, suspension, or adjustment of provider payments.

Information regarding the MDCH appeal process is available in the General Information for Providers Chapter and on the MDCH website. Refer to the Directory Appendix for website information.