

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



March 27, 2015

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

Dear Mr. Fitton:

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

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

Sincerely,

A handwritten signature in black ink that reads "Alan Freund". The signature is written in a cursive, flowing style.

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

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

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

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

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

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

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of restraints

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)****b. Use of Restrictive Interventions. (Select one):** **The State does not permit or prohibits the use of restrictive interventions**

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

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

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

The Michigan Mental Health Code 330.1726 requires (in part):

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

The Michigan Mental Health Code 330.1744 requires (in part):

- The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.

MDCH Administrative Rules 330.7199 requires (in part):

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

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

The functions of the Committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.

Restrictive and intrusive interventions reviewed by the Committee include:

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

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

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

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

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

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

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

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

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

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

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

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

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

The PIHP/CMHSP Behavior Treatment Plan Review Committee must, on a quarterly basis, track and analyze the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:

1. Dates and numbers of interventions used.
2. The settings (e.g., group home, day program) where behaviors and interventions occurred
3. Behaviors that initiated the techniques.
4. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
5. Attempts to use positive behavioral supports.
6. Behaviors that resulted in termination of the interventions.
7. Length of time of each intervention.
8. Staff development and training and supervisory guidance to reduce the use of these interventions.

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of seclusion

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

a. **Applicability.** Select one:

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

Yes. This Appendix applies (complete the remaining items)

b. **Medication Management and Follow-Up**

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

The SEDW services to which this appendix applies are: Respite provided in a foster home, therapeutic foster care, and therapeutic overnight camp. These settings are licensed under PA 116, as amended and the rules applicable thereto. While in any of these setting the waiver service provider would administer medications as prescribed by the physician.

The following rule applies to licensed family foster homes for children.

Rule 400.9411 Medical and dental care.

Rule 411. (1) A foster parent shall follow and carry out the health plan for a foster child as prescribed by a physician, health authority, or the agency.

(2) A foster parent shall follow agency approved protocols for medical care of a foster child who is injured or ill.

(3) A foster parent shall ensure that medications are inaccessible to children unless medically necessary.

(4) A foster parent shall ensure that prescription medication is given or applied as directed by a licensed physician.

The following rule applies to licensed camps for children.

R 400.11119 Health service policy.

Rule 119. (1) A camp shall have and follow a written health service policy that is appropriate to the population served and the environment of the campsite.

(2) A camp shall establish the health service policy in consultation with, and reviewed annually by, a licensed physician. (3) A camp's health service policy shall cover all of the following subjects:.....(f) The storage and administration of prescription and nonprescription drugs and medications.

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

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

Complete the following three items:

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

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

Performance Measure:

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

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. MDCH will analyze a 100% sample of all reported critical incidents involving SEDW consumers from the CIRS, as well as analyze subcategories of critical incidents reported through the CIRS including who required hospitalization due to an injury related to use of restrictive intervention or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDCH and the Quality Improvement Council are particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effectiveness of preventive strategies.

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

As indicated elsewhere in this application, each consumer has an IPOS developed based on the child's assessed needs and strengths. The IPOS also identifies a methodology to be used by staff for addressing identified needs. Safety and crisis plans are also developed for each consumer. Required staff training includes training in the IPOS, as well as in Recipient Rights. The IPOS is overseen by the Child and Family Team.

b. Methods for Remediation/Fixing Individual Problems

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

If an incident is reported to the CMHSP ORR or CMHSP, the system described in this Appendix would require the following steps be taken. Any critical incident for a consumer has a short-term response to assure the immediate health and welfare of the consumer for whom the incident was reported and a longer term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services, the agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the consumer's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDCH contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

Michigan's Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the HCBS waivers B/C Control # MI-14.R04, Habilitation Support Waiver(HSW)Control # 0167.90, Children's Waiver Control #4119.90, and the SEDW Control # 0438.01. The PIHPs/CMHSPs adhere to the same standards of care for each individual served and each PIHP/CMHSP meets the standards for certification as specified in the Mental Health Code and Medicaid Provider Manual. The MDCH QMP staff is responsible for implementing the QMP at the 18 PIHPs (comprised of all CMHSPs). MDCH sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs to conduct comprehensive biennial site reviews to ensure that Michigan's 1915 (c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all consumers served by Michigan's Section 1915 (c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers'.

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

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDCH staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:

- Includes services and supports that align with and address all assessed needs
- addresses health and safety risks
- is developed in accordance with MDCH policy and procedures, including utilizing person centered/family centered planning
- is updated at least annually

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

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

A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDCH in 30 days. MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDCH. Results of the MDCH on-site reviews are shared with MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

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

Michigan's QMP has been developed with the input of consumers and the Mental Health Quality Improvement Council (QIC) that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Service Boards. Michigan's QMP reflects the activities, concerns, input or recommendations from the Michigan Mental Health Commission, MDCHs Encounter Data Integrity Team, MDCHs Administrative Simplification Process Improvement Team, the 2007 External Quality Review (EQR), and the terms and conditions from CMS' previous waiver approvals.

The existing infrastructure in Michigan includes 1915(b) waiver authority to allow Michigan to provide mental health services not otherwise covered under the State plan through a managed care delivery system. The combined 1915(b) with the 1915(c) HSW enables Michigan to use typical Medicaid managed care program features such as quality improvement performance plans and external quality reviews to effectively monitor waiver programs. These same quality improvement performance plans and external quality reviews are used to monitor the CMHSPs in their provision of SEDW services. Because the SEDW is a fee-for-service program and is not covered under Michigan's managed care delivery system, the CMHSPs are the sub-state entity responsible for the day to day implementation of the SEDW.

Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the quality assessment and performance improvement programs. These elements were required as part of the AFP (2002) and are now part of the MDCH/CMHSP contracts; and they are reviewed by MDCH staff and/or the external quality review process. While a review of the following three areas is not specific to the SEDW, it assures overall quality services for all consumers.

EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. Very few clinical record reviews are completed as part of this process. One EQR Component addresses PIHP compliance to BBA requirements. The other two EQR activities, Performance Improvement Program Validation and Performance Measures Validation, have essentially no direct relationship to SEDW service delivery or quality management.

The following minimum standards for customer services are covered by the MDCH QMP on-site visit or the External Quality Review (EQR):

- a. Customer services operation is clearly defined.
- b. Customer service staff is knowledgeable about referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT).
- c. A range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSPs network.
- d. Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP.
- e. The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice.
- f. Customer services is managed in a way that assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications.
- g. The relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined organizationally and managerially in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Appeals and Grievances Mechanisms: The EQR reviews on-site the process, information to recipients and contractors, method for filing, provision of assistance to consumers, process for handling grievances, record-keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Appeals database to track the trends of the requests for fair hearing and their resolution and to identify CMHSPs that have particularly high volumes of appeals.

Quality Assessment and Performance Improvement Programs: The MDCH contracts with PIHP/CMHSPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors, on-site,

the PIHP/CMHSPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: Sentinel Events and credentialing of providers. MDCH collects data for performance indicators and performance improvement projects as described in b.i. below.

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the External Quality Reviews (EQR). The EQR consists of desk audits of PIHP documents, two-day on-site visits to PIHPs or both. The scope of the review includes: Validation of Performance improvement projects; Validation of performance indicators; and Compliance with Michigan's Quality Standards and BBA requirements.

In addition to the QMP strategies listed above that are implemented for all consumers, MDCH staff conduct reviews of all applications and re-certifications for the SEDW.

Data from site reviews and consultations has been used for systems improvement activities. Examples include: providing technical assistance to participating sites during monthly conference calls; mandating technical assistance for sites with high levels of out-of-compliance; completing additional follow up record reviews to ensure that fidelity to the Wraparound model is assured; developing workshops for the Annual Statewide Waiver and Wraparound conferences; developing materials to assist agencies and communities in assessing their readiness for participation in the SEDW; and identifying topics for technical assistance workshops at both state and local levels to address affective systems of care for this population.

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

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Other Specify: The QI Committee meets bi-monthly. For the PIHPs/CMHSPs and MDCH, QI activities are on-going.

b. System Design Changes

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

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

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

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

External Quality Review activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. The EQR consists of desk audits of PIHP documents, two-day on-site visits to PIHPs or both.

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

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

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

Performance Improvement Projects: The MDCH staff collaborates to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and stakeholder concerns. Michigan requires all PIHPs to conduct a minimum of two performance improvement projects. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH; in the case of PIHPs with affiliates, the project is affiliation-wide. All PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHPs choose their second performance improvement project.

Performance Indicators: Performance indicators are used to monitor the performance of the PIHP/CMHSP on a number of domains that have been identified as important quality strategies for the mental health system. The CMHSPs are required to report data for performance indicators. MDCH analyzes data against established standards, creates statewide averages and does comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action.

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts

to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. A Financial Status Report (FSR), certified by CMHSP Finance staff is submitted by each participating CMHSP. SEDW revenue and expenditures are uniquely identified on these FSRs, which also break out SEDW expenses by federal, local, and state funding sources. During the contract reconciliation and cash settlement process, MDCH staff reconciles the SEDW revenues reported by the CMHSP to the official MDCH records. Additionally, MDCH staff validate that the CMHSP has met the local match obligation by performing an analysis of the amount of expenditures reported as funded with local or state funding to the amount of expenditures reported as funded with federal SEDW revenues. Documentation for the contract reconciliation, cash settlement and the SEDW local match analysis is maintained in the Bureau of Finance.

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

The PIHP/CMHSP monitors claims through the services verification review process described above. A final report is prepared which details findings and discrepancies with financial implications, and corrective action taken or to be taken. In those instances where a recommendation is made regarding internal procedures, PIHP/CMHSP staff follow up with the provider on actions taken to correct and monitor identified deficiencies. If an identified problem rises to a level of fraud and abuse, the PIHP/CMHSP is required to report the finding to the MDCH Medicaid Fraud Unit for investigation and follow-up. If it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

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

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

The requirements for a Compliance Exam and the Financial Statement Audit do not replace or remove any other audit requirements that may exist, such as a Single Audit. If a PIHP or CMHSP expends \$500,000 or more in federal awards, they must obtain a Single Audit. Of the SEDW participating CMHSPs all but Livingston and Van Buren meet this requirement. In general, if a SEDW participating CMHSP is exempt from the Single Audit the SEDW must be tested as part of the CMHSP's Compliance Exam. In addition, if the Single Audit does not cover the SEDW then the SEDW may be tested as part of the Compliance Exam.

(b) Claims for services provided to SEDW enrollees, whether provided by a CMHSP or by a qualified provider contracted by the CMHSP are billed directly by the CMHSP to Medicaid through CHAMPS-the state's CMS approved claims processing system-in accordance with policies and procedures published in the "billing and reimbursement for professionals" section of the Michigan Medicaid Provider Manual. That portion of the manual also contains information about how claims are processed and how providers are notified of MDCH actions. The CMHSP may also choose to use a billing agent. CHAMPS applies a series of edits and determines the amount approved for payment. This is the lesser of the charge for the service or the Medicaid fee screen. Match for the federal share is provided in one of three ways: State General Fund dollars redirected by MDHS, State General Fund dollars allocated to CMHSPs by MDCH, and local funds allocated or approved by the CMHSP and their local partners.

The SEDW Site Review Team reviews Medicaid billing invoices, budgets and IPOS's. The review ensures that the services billed were identified in the POS as appropriate to identified needs, were recommended by the Child and Family Team, and were approved by the Community Team.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic claims submitted to Medicaid

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: proportinate random sample; 95% confidence level
	<input checked="" type="checkbox"/> Other Specify: biennial, statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

- ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method

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

Establishing Costs/Charges for Services:

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

Administrative Costs:

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

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

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

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

Medicaid Payment for Services:

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

Service claims are submitted to MDCH through CHAMPS (as detailed in I-2-b. below) and paid uniformly at the established Medicaid fee screen or billed charge, whichever is less.

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

Final Fee Screen Methodology:

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

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

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

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

- 4) The average charge per unit is calculated for each CMHSP for each service. The calculated average charge per unit is then arrayed in descending order by service.
- 5) Each service is reviewed to determine if there is a corresponding HCPCS code within the Medicare Physicians Fee Schedule for Michigan. Where one exists, that fee is set as the final SEDW fee screen. Where there is no corresponding code within the Medicare Physicians Fee Schedule for Michigan, the 90th percentile of the arrayed average unit charge is calculated and set as the final SEDW fee screen.
- 6) The final fee screens for services that can be provided to more than one (1) beneficiary at a time (e.g., T1005 - respite), are set at 75% of the corresponding final fee screen.
- 7) The final fee screens for services provided on holidays are set at 150% of the corresponding unmodified procedure's final fee screen.
- 8) For those procedures billed by only one CMHSP and to which none of the above rules apply, the interim screen is used and no adjustor payment is made.

Source of Non-Federal Share:

The non-Federal share of the interim payments is either paid with local General Fund or other local funds for one group of SEDW consumers or with an MDCH State appropriation for another group of SEDW consumers. As indicated in I-4 b. (Non-Federal Matching Funds, Local Government or Other Sources of the Non-Federal Share of Computable Waiver Costs, Appropriation of Local Government Revenues and Other Local Government Level Sources of Funds): County Boards of Commission have the authority to levy taxes and allocate a portion of general county funds (including property tax revenue) to CMHSPs to be used as local match. Cities and townships also have authority to appropriate funds to CMHSPs. As long as the source of revenue is not federal or state funds, revenues from other county departments and funds (such as child care funds) and from public or private school districts can be received by CMHSPs to use as local match for services. As indicated in I-4 a. (Non-Federal Matching Funds, State Level Sources of the Non-Federal Share of Computable Waiver Costs) the non-Federal share of the interim payments for the group of SEDW consumers in the DHS-Project population is paid with State General Fund dollars appropriated to, and redirected by, the Michigan Department of Human Services (MDHS). For both groups of SEDW consumers, interim payments are made as described below in I-2 b. Flow of Billings. As noted in I-1 Financial Integrity, validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract.

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

Responsible Entity:

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

Informing Waiver Consumers About Service Rates:

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

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

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

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

established fee-screen for each service.

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- No. State or local government agencies do not certify expenditures for waiver services.
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

(a) Participating CMHSPs

(b) & (c) Several vehicles are used to assure that the CPE is based on total computable costs for SEDW services: The Compliance Exam; Verification of fee-for-service billings by Medicaid staff and SEDW Site Review staff; and the contract reconciliation and cash settlement process. As described previously, the validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. A Financial Status Report (FSR), certified by CMHSP Finance staff is submitted from each of the participating CMHSPs. The SEDW revenue and expenditures are uniquely identified on the FSRs of the participating CMHSPs. SEDW expenses are broken out by federal, local, and state funding. During the contract reconciliation and cash settlement process, MDCH staff will reconcile the SEDW revenues reported by the CMHSP to the official MDCH records. Additionally, MDCH staff validate that the CMHSP has met the local match obligation by performing an analysis of the amount of expenditures reported as funded with local or state funding to the amount of expenditures reported as funded with federal SEDW revenues. The contract reconciliation and cash settlement documentation and SEDW local match analysis is maintained in the Bureau of Finance.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
 Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

As discussed in detail in I-1 above, claims for services provided to SEDW enrollees, whether provided by a CMHSP or by a qualified provider contracted by the CMHSP, are billed directly by the CMHSP to Medicaid through CHAMPS - the State's CMS-approved claims processing system - in accordance with policies and procedures published in the "billing and reimbursement for professionals" section of the Michigan Medicaid Provider Manual. That portion of the manual also contains information about how claims are processed and how providers are notified of MDCH actions. The CMHSP may also choose to use a billing agent. CHAMPS applies all appropriate edits to each claim line. (Edits include verifying the consumer was enrolled in the SEDW on the date-of-service, that the claim is for a billable service, that the quantity billed does not exceed the parameter for the service, and whether the consumer is enrolled in the DHS Pilot.) CHAMPS issues a Remittance Advice (RA) indicating status of the claim (e.g., pend, reject, paid) with applicable "reason/explanation" codes. The "amount approved for payment" is the lesser of charge or fee screen.

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

MDCH utilizes a coding reduction technique where a Program Cost Account (PCA) is required on all payments / accounting entries. The PCA identifies various characteristics of the payments, including but not limited to the appropriation and funding source. These elements identify everything needed to properly identify expenditures on the CMS-64. At the end of each quarter, MDCH Grants Management staff prepares and submits the CMS-64 utilizing standardized reports based on the elements defined on the PCA. In addition, the Mental Health and CSHCS Support Section within the Bureau of Finance, prepares a confirmation memo, which details the SEDW costs and anticipated federal reimbursement. The Grants Management staff reconciles what is reflected in the standardized reports to what is reflected in the confirmation memo prior to submission of the CMS-64.

The validation of the required local match is completed during the contract reconciliation and cash settlement process of the larger General Fund Contract. A Financial Status Report (FSR), certified by CMHSP Finance staff is submitted from each of the participating CMHSPs. The SEDW revenue and expenditures are uniquely identified on the FSRs of the participating CMHSPs. SEDW expenses are broken out by federal, local, and state funding. During the contract reconciliation and cash settlement process, MDCH staff will reconcile the SEDW revenues reported by the CMHSP to the official MDCH records. Additionally, MDCH staff validate that the CMHSP has met the local match obligation by performing an analysis of the amount of expenditures reported as funded with local or state funding to the amount of expenditures reported as funded with

federal SEDW revenues. The contract reconciliation and cash settlement documentation and SEDW local match analysis is maintained in the Bureau of Finance.

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

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I-3: Payment (4 of 7)

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

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

The providers of SEDW services include participating CMHSPs and other qualified/approved community-based mental health and developmental disability services providers. The waiver services they provide are identified in Appendix C.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (1 of 3)****a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:***

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- a) State General Fund dollars appropriated to, and redirected by, the Michigan Department of Human Services (MDHS). b) MDCH will report Medicaid expenditures on a quarterly basis to MDHS and MDHS will transfer State General Fund dollars to MDCH using an interagency journal voucher process. (MDCH sends DHS a quarterly billing of the applicable gross expenditures for SED services; and MDHS reimburses MDCH the GF share at the current year FMAP rate.) The redirected State funds are used as State match for waiver services provided to children in the foster care system, identified by MDHS, and determined eligible for the SED Waiver.
- Other State Level Source(s) of Funds.**

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

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (2 of 3)**

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

(a) & (b) County Boards of Commission have the authority to levy taxes and allocate a portion of general county funds (including property tax revenue) to CMHSPs to be used as local match. Cities and townships also have authority to appropriate funds to CMHSPs.

(c) Funds are directly expended by participating CMHSPs as specified in Item I-2-c.

Other Local Government Level Source(s) of Funds.

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

(a) & (b) As long as the source of revenue is not federal or state funds, revenues from other county departments and funds (such as child care funds) and from public or private school districts can be received by CMHSPs to use as local match for services.

(c) Funds are directly expended by participating CMHSPs as specified in Item I-2-c.

Appendix I: Financial Accountability**I-4: Non-Federal Matching Funds (3 of 3)**

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability**I-5: Exclusion of Medicaid Payment for Room and Board**

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

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The following waiver services can be provided to SEDW consumers in residential settings other than the individual's private residence: child therapeutic foster care (can be provided in a Department of Human Services (DHS) licensed foster home), and therapeutic overnight camp (can be provided in a DHS licensed camp).

DHS, Michigan's child welfare organization, licenses and regulates children's foster care. The current approved rate for room and board is based on age and is as follows, and is not billable to Medicaid:

Age Group	Room & Board
0-12	\$17.24
13-18	\$20.59

The Therapeutic Foster Care rate for the SEDW is comprised of 3 components, 2 of which are billable to Medicaid; 1 which is not.

1. The daily rate covers \$75.00 per day for the enhanced therapeutic rate to be paid to foster parents. This rate includes respite care (purchased by the foster parent), participation in wraparound team meetings, training and other treatment-oriented appointments for the youth and family, data collection required as part of implementing the POS (including a daily/weekly log and 24 hour supervision).
2. The daily rate also includes \$35.00 per day to be paid to the provider agency. This part of the daily rate includes recruitment, pre-service training and licensing of the foster parents for this specialized service; on-going support, monitoring, training and oversight of the foster home; as well as closely supervised home visits throughout the youth's placement in the foster home.
3. Room and Board rate paid to Foster Parents: This must be paid separate from the enhanced therapeutic foster care rate and from a different funding source (e.g., Title IV-E); Medicaid cannot be used to pay this component. The room and board rate includes basic needs, including clothing, shelter, food and daily essentials. The Room and Board rate is based on the child's age:
 - a.) Age birth - 12: \$17.24 a day
 - b.) Age 13 - 18: \$20.59 a day

Therapeutic Overnight Camping (per session): CMHSPs and other approved community-based mental health and developmental disability services providers must contract with DHS licensed camps for this service. Contracts for all providers must specify performance expectations. In the case of licensed camps, performance expectations include the length of the session and detail of all costs (e.g., cost of staff with specialized training with this population, enrollment and other camp fees, transportation to and from the camp) included in the charge for the session. The contracted rate must exclude the cost of room and board. This is accomplished in 1 of 2 ways: subtracting the applicable room & board rate (see table above) for each day of the camp session from the total charge for the session; or subtracting the cost attributed to room and board in the detailed cost of the session.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

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

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

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

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

i. **Co-Pay Arrangement.**

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

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

- Nominal deductible
 Coinsurance
 Co-Payment
 Other charge

Specify:

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

a. **Co-Payment Requirements.**

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

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

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

a. **Co-Payment Requirements.**

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

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

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

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

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

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

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

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8572.65	10152.31	18724.96	33599.86	1484.67	35084.53	16359.57
2	8572.45	10289.37	18861.82	34053.46	1504.71	35558.17	16696.35
3	8572.45	10428.27	19000.72	34513.18	1525.03	36038.21	17037.49
4	8572.45	10569.06	19141.51	34979.11	1545.62	36524.73	17383.22
5	8572.45	10711.74	19284.19	35451.33	1566.48	37017.81	17733.62

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	804	804	
Year 2	969	969	
Year 3	969	969	
Year 4	969	969	
Year 5	969	969	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) for waiver years 1 through 5 (FY 2014 thru FY 2018) of this Renewal Application is based on the ALOS as reported on the CMS-approved annual 372 for FY11; that ALOS was 208.1 days.

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (3 of 9)**

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

(a) The estimated number of service users and the estimated number of units per user were determined in 3 ways: 1) Utilization data from the CMS-approved 372 report for FY11 was used as the basis for calculation of the various elements of Factor D for all services except Community Transition, Family Support and Training and Home Care Training, Non-Family. FY11 utilization data was expressed as a percent and applied to the number of enrollees for which we are requesting approval. The estimated number of units per user was extrapolated from paid-claim data for FY11. 2) For services that were not used during Waiver Year 3 (i.e., Family Support and Training and Community Transition) the estimated number of users from the approved amendment for Waiver Years 2 and 3, respectively, were expressed as a percent and applied to the number of enrollees for which we are requesting approval for Renewal Waiver Years 1 through 5. The number of units per consumer are as estimated for Waiver Years 2 and 3 for each service. 3) Estimated utilization of Home Care Training, Non-Family (for which FY11 data isn't available because the service was added halfway through FY12) is based on estimated utilization of this service for Waiver Year 4 of the approved amendment.

Please Note: When using actual 372 data for projections, it was not possible to exactly match the 372 data for both expenditures and the unduplicated number of consumers using a service when also estimating the average usage of each service because estimates are based on Medicaid fee-screens and claims are paid at the lesser of charge or fee-screen. Our approach is to prepare the demonstration of Factor D based on the actual number of consumers using each service as reported on the 372 and the actual Factor D value (average per capital expenditures for waiver services) as reported on the 372.

(b) The average cost per unit of service is based on the Medicaid Fee Screens, and claims are paid at the lesser of charge or fee screen. No increase in Medicaid fee screens for waiver services is anticipated, therefore no projected growth rate was built into the average unit cost for any service.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Data from the CMS-approved annual 372 report for FY11 was used as the basis for calculation of D' for waiver years 1 through 5 of the renewal application. Medicaid expenditures for other services provided to SEDW enrollees are projected to grow at a rate of 1.35%. The State is using a trend of State historical cost increases as predictive of future costs. Historical cost increases for SEDW waiver and mental health State Plan services from FY 08 – FY 11 were smoothed linearly to produce an annualized trend rate during that period. This annualized historical trend rate is, in our opinion, the best estimate of future costs for this population and includes the impact of practice patterns and utilization per member/per month. Hospital payments for DSH, TEFRA and GME are not included in the D' estimates.

There is no further adjustment in D' as there are no dually eligible (Medicare / Medicaid) consumers served by the SEDW, although they are eligible. There were no Medicare Part D expenditures for SEDW recipients in FY11, and none are anticipated for FY14 through FY18.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was extrapolated from paid-claim data for used to prepare the CMS 372 report for FY11. Medicaid expenditures for psychiatric hospitalization (at Hawthorn) for FY11 were trended forward at a growth rate of 1.35% for Waiver Years 1 through 5 of the Renewal.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was extrapolated from paid-claim data used to prepare the CMS 372 report for FY11. The estimated annual average per capita cost to Medicaid for all other services provided to individuals while the individual was in a psychiatric hospital was trended forward at a growth rate of 1.35% for Waiver Years 1 through 5 of the Renewal.

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (4 of 9)**

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Respite	
Child Therapeutic Foster Care	
Community Living Supports	

Waiver Services	
Community Transition	
Family Home Care Training	
Family Support and Training	
Home Care Training, Non-Family	
Therapeutic Activities	
Therapeutic Overnight Camping	
Wraparound	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							1912627.20
Respite	<input type="checkbox"/>	15 minutes	283	1056.00	6.40	1912627.20	
Child Therapeutic Foster Care Total:							23100.00
Child Therapeutic Foster Care	<input type="checkbox"/>	day	5	42.00	110.00	23100.00	
Community Living Supports Total:							1043328.00
Community Living Supports	<input type="checkbox"/>	15 minutes	228	715.00	6.40	1043328.00	
Community Transition Total:							30550.00
Community Transition	<input type="checkbox"/>	one time only	47	1.00	650.00	30550.00	
Family Home Care Training Total:							122850.00
Family Home Care Training	<input type="checkbox"/>	session	117	7.00	150.00	122850.00	
Family Support and Training Total:							309680.00
Family Support and Training	<input type="checkbox"/>	session	79	49.00	80.00	309680.00	
Home Care Training, Non-Family Total:							184966.11
Home Care Training, Non-Family	<input type="checkbox"/>	session	331	9.00	62.09	184966.11	
Therapeutic Activities Total:							665.40
GRAND TOTAL:							6892406.71
Total: Services included in capitation:							6892406.71
Total: Services not included in capitation:							804
Total Estimated Unduplicated Participants:							8572.65
Factor D (Divide total by number of participants):							
Services included in capitation:							8572.65
Services not included in capitation:							208
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Activities	<input type="checkbox"/>	session	2	5.00	66.54	665.40	
Therapeutic Overnight Camping Total:							117600.00
Therapeutic Overnight Camping	<input type="checkbox"/>	session	42	2.00	1400.00	117600.00	
Wraparound Total:							3147040.00
Wraparound	<input type="checkbox"/>	day	712	13.00	340.00	3147040.00	
GRAND TOTAL:							6892406.71
Total: Services included in capitation:							6892406.71
Total: Services not included in capitation:							804
Total Estimated Unduplicated Participants:							8572.65
Factor D (Divide total by number of participants):							
Services included in capitation:							8572.65
Services not included in capitation:							208
Average Length of Stay on the Waiver:							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							2304614.40
Respite	<input type="checkbox"/>	15 minutes	341	1056.00	6.40	2304614.40	
Child Therapeutic Foster Care Total:							27720.00
Child Therapeutic Foster Care	<input type="checkbox"/>	day	6	42.00	110.00	27720.00	
Community Living Supports Total:							1258400.00
Community Living Supports	<input type="checkbox"/>	15 minutes	275	715.00	6.40	1258400.00	
Community Transition Total:							36400.00
Community Transition	<input type="checkbox"/>	one time only	56	1.00	650.00	36400.00	
Family Home Care Training Total:							148050.00
Family Home Care Training	<input type="checkbox"/>	session	141	7.00	150.00	148050.00	
GRAND TOTAL:							8306707.69
Total: Services included in capitation:							8306707.69
Total: Services not included in capitation:							969
Total Estimated Unduplicated Participants:							8572.45
Factor D (Divide total by number of participants):							
Services included in capitation:							8572.45
Services not included in capitation:							208
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Support and Training Total:							372400.00
Family Support and Training	<input type="checkbox"/>	session	95	49.00	80.00	372400.00	
Home Care Training, Non-Family Total:							222965.19
Home Care Training, Non-Family	<input type="checkbox"/>	session	399	9.00	62.09	222965.19	
Therapeutic Activities Total:							998.10
Therapeutic Activities	<input type="checkbox"/>	session	3	5.00	66.54	998.10	
Therapeutic Overnight Camping Total:							142800.00
Therapeutic Overnight Camping	<input type="checkbox"/>	session	51	2.00	1400.00	142800.00	
Wraparound Total:							3792360.00
Wraparound	<input type="checkbox"/>	day	858	13.00	340.00	3792360.00	
GRAND TOTAL:							8306707.69
Total: Services included in capitation:							
Total: Services not included in capitation:							8306707.69
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							8572.45
Services included in capitation:							
Services not included in capitation:							8572.45
Average Length of Stay on the Waiver:							208

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							2304614.40
Respite	<input type="checkbox"/>	15 minutes	341	1056.00	6.40	2304614.40	
Child Therapeutic Foster Care Total:							27720.00
Child Therapeutic Foster Care	<input type="checkbox"/>	day	6	42.00	110.00	27720.00	
Community Living Supports Total:							1258400.00
GRAND TOTAL:							8306707.69
Total: Services included in capitation:							
Total: Services not included in capitation:							8306707.69
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							8572.45
Services included in capitation:							
Services not included in capitation:							8572.45
Average Length of Stay on the Waiver:							208

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Supports	<input type="checkbox"/>	15 minutes	275	715.00	6.40	1258400.00	
Community Transition Total:							36400.00
Community Transition	<input type="checkbox"/>	one time only	56	1.00	650.00	36400.00	
Family Home Care Training Total:							148050.00
Family Home Care Training	<input type="checkbox"/>	session	141	7.00	150.00	148050.00	
Family Support and Training Total:							372400.00
Family Support and Training	<input type="checkbox"/>	session	95	49.00	80.00	372400.00	
Home Care Training, Non-Family Total:							222965.19
Home Care Training, Non-Family	<input type="checkbox"/>	session	399	9.00	62.09	222965.19	
Therapeutic Activities Total:							998.10
Therapeutic Activities	<input type="checkbox"/>	session	3	5.00	66.54	998.10	
Therapeutic Overnight Camping Total:							142800.00
Therapeutic Overnight Camping	<input type="checkbox"/>	session	51	2.00	1400.00	142800.00	
Wraparound Total:							3792360.00
Wraparound	<input type="checkbox"/>	day	858	13.00	340.00	3792360.00	
GRAND TOTAL:							8306707.69
Total: Services included in capitation:							
Total: Services not included in capitation:							8306707.69
Total Estimated Unduplicated Participants:							969
Factor D (Divide total by number of participants):							8572.45
Services included in capitation:							
Services not included in capitation:							8572.45
Average Length of Stay on the Waiver:							208

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							2304614.40
Respite	<input type="checkbox"/>	15 minutes	341	1056.00	6.40	2304614.40	
Child Therapeutic Foster Care Total:							27720.00
Child Therapeutic Foster Care	<input type="checkbox"/>	day	6	42.00	110.00	27720.00	
Community Living Supports Total:							1258400.00
Community Living Supports	<input type="checkbox"/>	15 minutes	275	715.00	6.40	1258400.00	
Community Transition Total:							36400.00
Community Transition	<input type="checkbox"/>	one time only	56	1.00	650.00	36400.00	
Family Home Care Training Total:							148050.00
Family Home Care Training	<input type="checkbox"/>	session	141	7.00	150.00	148050.00	
Family Support and Training Total:							372400.00
Family Support and Training	<input type="checkbox"/>	Session	95	49.00	80.00	372400.00	
Home Care Training, Non-Family Total:							222965.19
Home Care Training, Non-Family	<input type="checkbox"/>	session	399	9.00	62.09	222965.19	
Therapeutic Activities Total:							998.10
Therapeutic Activities	<input type="checkbox"/>	session	3	5.00	66.54	998.10	
Therapeutic Overnight Camping Total:							142800.00
Therapeutic Overnight Camping	<input type="checkbox"/>	session	51	2.00	1400.00	142800.00	
Wraparound Total:							3792360.00
Wraparound	<input type="checkbox"/>	day	858	13.00	340.00	3792360.00	
GRAND TOTAL:							8306707.69
Total: Services included in capitation:							8306707.69
Total: Services not included in capitation:							969
Total Estimated Unduplicated Participants:							8572.45
Factor D (Divide total by number of participants):							8572.45
Services included in capitation:							8572.45
Services not included in capitation:							208
Average Length of Stay on the Waiver:							

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							2304614.40
Respite	<input type="checkbox"/>	15 minutes	341	1056.00	6.40	2304614.40	
Child Therapeutic Foster Care Total:							27720.00
Child Therapeutic Foster Care	<input type="checkbox"/>	day	6	42.00	110.00	27720.00	
Community Living Supports Total:							1258400.00
Community Living Supports	<input type="checkbox"/>	15 minutes	275	715.00	6.40	1258400.00	
Community Transition Total:							36400.00
Community Transition	<input type="checkbox"/>	one time only	56	1.00	650.00	36400.00	
Family Home Care Training Total:							148050.00
Family Home Care Training	<input type="checkbox"/>	session	141	7.00	150.00	148050.00	
Family Support and Training Total:							372400.00
Family Support and Training	<input type="checkbox"/>	Session	95	49.00	80.00	372400.00	
Home Care Training, Non-Family Total:							222965.19
Home Care Training, Non-Family	<input type="checkbox"/>	session	399	9.00	62.09	222965.19	
Therapeutic Activities Total:							998.10
Therapeutic Activities	<input type="checkbox"/>	session	3	5.00	66.54	998.10	
Therapeutic Overnight Camping Total:							142800.00
Therapeutic Overnight Camping	<input type="checkbox"/>	session	51	2.00	1400.00	142800.00	
Wraparound Total:							3792360.00
Wraparound	<input type="checkbox"/>	day	858	13.00	340.00	3792360.00	
GRAND TOTAL:							8306707.69
Total: Services included in capitation:							8306707.69
Total: Services not included in capitation:							969
Total Estimated Unduplicated Participants:							8572.45
Factor D (Divide total by number of participants):							8572.45
Services included in capitation:							8572.45
Services not included in capitation:							208
Average Length of Stay on the Waiver:							208