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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

The CWP is transitioning from fee-for-service to managed care. Michigan is also adding another service (Overnight Health and Safety Support)to the CWP array of covered services.

The CWP is also adding 100 additonal slots which will change from 469 to 569 slots. This change will occur gradually over the first 3 years of the 5 year waiver period to allow for collection and analysis of data to assure the MDHHS continues to operate the waiver within the approved appropriation. (Waiver year-1 469 slots, year-2 519 slots, year-3,4 and 5 569 slots).

MDHHS transition plan includes an orientation webinar and operations webinars for PIHPs and CMHSPs. Continued Waiver Support Application (WSA) training. A kick-off webinar prior to implementation to cover updates, and to answer any questions.

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

1. Request Information (1 of 3)

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

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

Children's Waiver Program

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.4119
Draft ID: MI.012.06.00

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

Regular Waiver

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

10/01/19

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☒ **A program authorized under §1115 of the Act.**
Specify the program:

1115 Pathway to Integration

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Children's Waiver Program (CWP) is to provide community-based services to children under age 18 who, if not for the availability and provisions of CWP services would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded (ICF/IDD). The goal of the CWP is to enable children with developmental disabilities who have significant needs and who meet the CWP eligibility requirements to live with their parents or legal guardians and to fully participate in their communities. The objective is to provide regular Medicaid State Plan services and waiver services that address the child's/youth's identified needs.

Waiver services include: Respite; Enhanced Transportation; Community Living Supports; Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies; Family Support and Training; Home Care Training (Family); Home Care Training (Non-Family); Financial Management Services; Specialty Services (i.e., music, recreation, art and massage therapy) and Overnight Health and Safety Support.

Oversight of the CWP is provided by the Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. Two administrations within MDHHS – Behavioral Health and Development Disabilities Administration (BHDDA) and the Medical Services Administration (MSA) have responsibility for operations and payments, respectively. The CWP is a Managed Care program administered locally by Prepaid Inpatient Health Plans (PIHPs) under contract with MDHHS. Services are provided by the PIHP, its affiliate community mental health services programs (CMHSPs) if applicable or its contracted entities. Services are provided directly by PIHPs, their contracted providers and/or providers of the consumer's choice through Financial Management Services under Choice Voucher arrangements and Purchase of Service contracts. When medically necessary, CWP consumers may receive any of the Mental Health State Plan services and waiver services identified in Appendix C of this §1915(c) renewal waiver application. Consumers enrolled in the CWP may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

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

waiver.

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

Tribal Notice is Monday, April 15th, 2019.

Public Notice and Stakeholder L-Letter is May 15th, 2019.

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

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Coleman

First Name: Jacqueline

Title: Waiver Specialist

Agency: Medical Services Administration, MDHHS

Address: 400 South Pine St.

Address 2: P.O. 30479

City: Lansing

State: **Michigan**

Zip: 48909

Phone:

(517) 284-1190 **Ext:** ☐ **TTY**

Fax:

(517) 241-5112

E-mail:

ColemanJ@michigan.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The requested effective date for the change from Fee-for-Service to a Managed Care Entity is 10/01/2019. This change and technical guidance related to planning for this change, will be communicated in writing to PIHPs in the Fall of 2019 and will be discussed at the Annual Waiver's Conference scheduled for November, 2019.

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

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

After conducting an initial review of settings under this waiver program, MDHHS determined that settings under this waiver should be presumed to be compliant with the rule. All children under this waiver program are served in family homes, which have presumed compliance under the rule. MDHHS will not be assessing individual settings under this waiver program.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

(Do not complete item A-2)

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

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

Michigan Department of Health and Human Services - Behavioral Health and Develomental Disabilities Administration

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

a)The Michigan Department of Health and Human Services (MDHHS) is the Single State Medicaid Agency and is comprised of three administrations: The Medicaid Services Administration (MSA), which administers Medicaid for MDHHS; the Behavioral Health and Developmental Disabilities Administration (BHDDA), which operates the Habilitation Supports Waiver and other mental health programs; and the Public Health Administration. More specifically, the MDHHS-BHDDA performs the following operational and administrative functions: all administrative functions related to the CWP including review and approval of initial waiver applications submitted by Prepaid Inpatient Health Plans (PIHPs), waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS assurances, including financial accountability. Additionally, MDHHS-BHDDA staff approve or certify some programs, disseminate information concerning the waiver to potential enrollees and service providers, assist individuals in waiver enrollment, manage waiver enrollment against approved limits, monitor waiver expenditures against approved levels, monitor level of care evaluation activities, conduct site reviews, conduct utilization management functions, determine waiver managed care average costs per unit, conduct training and technical assistance (including providing input for updating the Medicaid Provider Manual) concerning waiver requirements and implementation.

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

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

PIHPs are delegated the responsibility to perform the following functions: disseminating information concerning the waiver to potential enrollees; assisting individuals in applying for waiver enrollment; managing waiver enrollments within the PIHP's allocation; gathering information for MDHHS to conduct the level of care evaluation activities for re- certifications; assuring participants have been given freedom of choice of providers and have consented to CWP services in lieu of ICF/IID; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the participant's needs; conducting prior authorization or utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining, monitoring and managing the qualified provider network for managed care and CWP services.

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The MDHHS-BHDDA is responsible for assessing the performance of the PIHPs in conducting waiver operational and administrative functions. MDHHS monitors PIHPs through the site review process, financial reviews, and waiver enrollment oversight. The review protocols used by both the Federal Compliance Section - which includes CWP staff - are organized in a way that addresses the functions delegated by MDHHS to the participating PIHPs for the CWP. The delegated functions included in the review protocol are: level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; provider qualifications and enrollment; and quality assurance and quality improvement activities. MDHHS manages enrollment against approved limits by reviewing, approving and processing applications and renewal certifications submitted by PIHPs and by processing terminations submitted by PIHPs.

Appendix A: Waiver Administration and Operation

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

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

Within MDHHS-BHDDA, the Bureau of Community Based Services has responsibility for operation of the CWP on a day-to-day basis. This includes: monitoring and managing the CWP annual appropriation; managing waiver enrollment against approved limits; performing Prior Authorization of selected services for the CWP; establishing clinical eligibility for the waiver; conducting and monitoring quality assurance at the PIHP level; providing training and technical assistance concerning waiver requirements; completing CWP waiver renewal applications, amendments and CMS-372 reports for submission to CMS; reviewing and consulting with PIHPs when the Site Review Team has identified issues related to delegated functions; monitoring health and welfare issues by way of recipient rights complaints, sentinel events, Medicaid fair hearing requests, and the use of restrictive or intrusive behavioral interventions.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of PIHPs that implement quality assurance/improvement activities as

required by contract. Numerator: Number of PIHPs that implement required quality assurance/improvement activities. Denominator: All PIHPs.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The Federal Compliance Section includes a full review on a biennial basis and a follow-up review in the alternate years. A proportionate random sample of CWP consumer records is selected for the full on-site review. For performance measures related to timely remediation of issues of level of care, plan of service, and qualified providers, the data source is remediation evidence submitted by PIHPs for 100% of the issues identified during the site review. Timely remediation is completed within 90 days after the PIHPs plan of correction has been approved by MDHHS-BHDDA.

Michigan's comprehensive quality improvement program includes CWP consumers, but is not exclusive to them. In addition to the measures included in the biennial site review process, the External Quality Review (EQR) is an additional strategy employed by the State to discover problems and identify trends. EQR activities primarily focus on the presence of PIHP policies and processes and evidence that those policies and processes are being implemented. The EQR activities of "Performance Improvement Program Validation and Performance Indicators Validation" provide a mechanism for discovering problems / issues that affect services provided to all consumers of mental health services, including consumers on the CWP.

The Federal Compliance site review process also includes a comprehensive administrative review focused on policies, procedures, and initiatives that are not otherwise reviewed by the (EQR) and which need improvement as identified through the performance indicator system, billing/reimbursement data, grievance and appeals tracking, sentinel event reports, and consumer complaints.

b. Methods for Remediation/Fixing Individual Problems

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

As described in a.ii. above, a standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs which are required to submit plans of correction to MDHHS-BHDDA within 30 days. The plans of correction are reviewed by staff that completed the site review and are subsequently reviewed and approved by MDHHS-BHDDA. The PIHP has 90 days after the plan of correction has been approved to provide evidence to MDHHS-BHDDA that all issues have been remediated. MDHHS-BHDDA will maintain a log to track identified problems and remediation of individual problem. The remediation process continues until all concerns have been appropriately addressed. If the PIHP is having difficulty meeting the timeframes for remediation, MDHHS-BHDDA staff will work with the PIHP to identify strategies to improve timeliness.
On an ongoing basis, customer service functions at the MDHHS-BHDDA and the PIHPs provide assistance to individuals with problems and inquiries regarding services. This would include consumers in the CWP. As part of customer services within MDHHS-BHDDA, the CWP staff also handle multiple consumer phone and Email inquiries per month and work with the consumer and PIHP to address the issues or concerns

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

○ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete*

Items B-2-b and B-2-c.

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the

participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	469
Year 2	519
Year 3	569
Year 4	569
Year 5	569

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

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

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	500
Year 2	500
Year 3	500
Year 4	500
Year 5	500

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Children with Medicaid are not placed on a waiting list for Medicaid State Plan services and the PIHP must provide mental health services and supports appropriate to need. The CWP offers necessary services and supports beyond what is available under the Medicaid State Plan to children with developmental disabilities whose needs have placed them at risk for health, safety and/or out-of-home placement. Prior to considering a request for CWP services, the PIHP must review and utilize all available and appropriate Medicaid State Plan services for the child. If the PIHP determines that a child remains at risk and meets criteria for ICF/IDD, a CWP pre-screen is completed and submitted to MDHHS.
A child identified as “at-risk" must have their urgent care needs met by the PIHP to ensure health, welfare, and safety while the child remains on the CWP Priority Weighing List. The PIHP must assess the child’s needs and develop an Individual Plan of Service (IPOS) through the person centered / family driven / youth guided planning (PCP) process.

A request for CWP services begins with a pre-screen completed by a Qualified Intellectual Disability Professional (QIDP) and the child’s parent(s). Determination of severity of need is based on program-specific criteria. The CWP Priority Weighing Criteria provides a consistent and objective basis on which to determine the priority status of children who may be eligible for the program. The QIDP must meet with the child’s family and provide detailed information on CWP service parameters and program requirements. This includes eligibility requirements, available services, access to all qualified providers, opportunities for family participation in planning and active treatment, and financial disclosure requirements. After this discussion, if the family wishes to have their child considered for the CWP, the QIDP completes a pre-screen. The pre-screen identifies those services to be provided by the CMHSP, based on the child’s identified needs. A parent must sign the completed pre-screen and a copy must be maintained in the child’s record. The QIDP then submits the pre-screen to MDHHS.

Several factors associated with health, safety, well-being and risk of out-of-home placement comprise the CWP Priority Weighing Criteria. When reviewing a pre-screen, the BHDDA-CWP staff determines the score for each of these factors based on the information submitted. The scores for each factor are then totaled. A cover memo and scoring form are completed for each pre-screen and copies are mailed to the QIDP to review with the family. If the cover memo contains questions about the pre-screen or indicates the availability of other potential resources, the QIDP should follow up and provide updated information to BHDDA. Re-scoring occurs when updated information is received by MDHHS. If there are subsequent changes in the child or family’s situation that would affect a child’s score based on the Priority Weighing Criteria, the QIDP should submit a brief update letter describing relevant changes. The PIHP is responsible for updating the pre-screen at least annually in order for the child to remain on the Priority Weighing List.

The Priority Weighing List contains a sequential list of all pre-screen scores. The Priority Weighing List is updated each time pre-screens are scored. When a CWP opening becomes available, all pre-screens that have been received and date stamped at MDHHS are scored before a determination is made as to who will be invited to apply for the CWP opening. The child whose pre-screen is current, and who has the highest score, is invited to proceed with the CWP application process. The QIDP is notified by phone and asked to contact the family immediately to begin the formal application process.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

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

- (●) **No**

○ **Yes**

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

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

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

☒ **SSI recipients**

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

☐ **Optional state supplement recipients**

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

Select one:

◉ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

  Specify the entity:

- ( ) **Other**
  Specify:

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

PIHPs complete a CWP assessment to provide a child with an individual LOC evaluation. PIHP personnel conducting the LOC evaluations and reevaluations are qualified as physicians or Qualified Intellectual Disability Professional (QIDP), as defined in 42 CFR 483.430 and the Michigan Medicaid Provider Manual (MPM). The MPM, states that: "Individual with specialized training or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor or a human services professional with a bachelor’s degree or higher in a human services field (including but not limited to criminal justice, psychology, or sociology) in which the curriculum provided a good understanding of human behavior and the needs of population that they will be serving, as well as training in intervention methods that are useful in the public behavioral health system.

NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, his/her QIDP status will be grandfathered in to the new agency.

For the CWP, the person completing the level-of-care evaluation must also have completed Michigan Department of Health and Human Services (MDHHS) sponsored training in determining Category of Care (COC) and Intensity of Care (IOC). Prior to submission to MDHHS, the PIHP's designee reviews and approves the assigned level-of-care, as specified on the CWP Certification. The designee's signature attests to the fact the consumer meets the required institutional LOC and that the person who made the determination was qualified to do so.

Documentation of the child's LOC, as submitted by the PIHP, is reviewed and approved by the MDHHS staff. The CWP staff that reviews the packet is a QIDP.

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

Children evaluated for the Children's Waiver Program (CWP) must meet the admission criteria for an ICF/IDD as specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. and as identified in the Michigan Medicaid Provider Manual (MPM). Section 3.13 of the MPM states: "Beneficiaries must meet ICF/IDD level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a Qualified Intellectual Disability Professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications."

The State does not use a level-of-care instrument, per se. The method for determining LOC is as follows: The QIDP reviews any relevant supporting documentation regarding the child's functional skills (e.g., clinical assessments, individual educational plans from the child's school, medical reports) to determine whether the child meets ICF/IDD level of care criteria as delineated in 42 CFR 483.440.

The process / method used to evaluate LOC for the waiver is the same as used to evaluate institutional LOC.

The State ensures consistency in the LOC determination in four ways. First, at the level of the PIHP, individual LOC determinations/re-evaluations are reviewed by the QIDP's supervisor or by another administrator designated by the PHIP. This review is evidenced by the designee's signature on the waiver certification form. Second, consistency across PIHPs is monitored and assured by the site review process, which reviews relevant supporting documentation regarding the child's functional skills (e.g., clinical assessments, individual educational plans from the child's school, medical reports) to confirm the ICF/IDD LOC determination made by the PIHP. Third, MDHHS staff provide on-going technical assistance, training and consultation on LOC determination and documentation. Fourth, LOC determinations are reviewed MDHHS CWP staff who is a QIDP.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

The Michigan Medicaid Provider Manual(MMPM), Section 2.5.A. defines Medical Necessity Criteria for mental health, developmental disabilities, and substance abuse services for supports, services, and treatment as follows: "Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity."

Section 2.5.B. defines the Determination Criteria of a medically necessary support, service or treatment as: "Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and for beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and made within federal and state standards for timeliness; and sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and documented in the individual plan of service."

When a child is invited to apply for the CWP, a QIDP completes an assessment (as described above) and reviews any relevant supporting documentation regarding the child's functional skills (e.g., clinical assessments, individual educational plans from the child's school, medical reports) to determine whether the child meets ICF/IDD level of care criteria. The LOC determination is reviewed by the QIDP's supervisor.
The LOC is documented by the PIHP-designee's signature on the Waiver Certification Form. A copy of the Waiver Certification form is sent to the Michigan Department of Health and Human Services (MDHHS) and is reviewed and an eligibility evaluation is completed by the CWP staff.

The process / method used for reevaluating LOC for waiver applicants is the same as the process / method for evaluation of the child's LOC.

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

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

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

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

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

CWP enrollment data is maintained in the Web Support Application (WSA) and is used to identify children coming up for reevaluation/recertification. The PIHP/CMHSP can access a report in the WSA that identifies when reevaluation/recertifications are due for the children they serve. PIHP must submit a reevaluation/recertification packet within 365 days of the previous year's certification, as stated above. MDHHS also monitors the statewide report to track past due reevaluations/recertifications. If necessary, CWP staff contact the PIHP and instruct them to provide either a recertification or termination and notification to the family of Right to Hearing.

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

The PIHP maintains clinical records that include the Children's Waiver Program (CWP) initial and reevaluation / re-certification packets, along with supporting documentation. The MDHHS maintains copies of the initial and re-certification packets and approval letters and maintains a copy of notification of both the initial and continuing eligibility for the CWP.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
Number and percent of newly enrolled waiver consumers who have a need for an ICF/IDD level of care (LOC) prior to receipt of services. Numerator: Number of newly enrolled waiver consumers who have received an ICF/IDD LOC prior to receipt of services. Denominator: All new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
waiver certification form

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled waiver consumers that are reevaluated within 12 months of their initial level of care (LOC) evaluation or their last annual LOC reevaluation. Numerator: Number of enrolled consumers whose LOCs were reevaluated within 12 months of their last LOC evaluation. Denominator: All enrolled consumers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
waiver certification form

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of LOC evaluations that are completed accurately and documented on the CWP certification form. Numerator: Number of LOC evaluations that are completed accurately and documented on the CWP certification form. Denominator: All LOC evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
waiver certification form

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

	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionte random sample
	☒ **Other** Specify: biennial statewide data gathered over a 2-yr period of time	

Data Aggregation and Analysis:

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

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

Children evaluated for the CWP must meet the admission criteria for an ICF/IDD and require a continuous active treatment program directed toward acquisition of behaviors and skills necessary to function with as much participant direction and independence as possible in the home and community setting. The method for determining LOC is as follows: The QIDP reviews any relevant supporting documentation regarding the child's functional skills (e.g., clinical assessments, individual educational plans from the child's school, medical reports) to determine whether the child meets ICF/IDD level of care criteria as delineated in 42 CFR 483.440 and in the November 2000 TechnicalAdvisory "Michigan Department of Health and Human Services Mental Health and Substance Abuse Services Operational Compliance: Admissions to Centers for Developmental Disabilities". The process / method used to evaluate LOC for the waiver is the same as used to evaluate institutional LOC.
The Prepaid Inpatient Health Plans (PIHPs) complete a CWP assessment, as described above, to provide a child with an individual Level of Care (LOC) evaluation to determine if the child meets admission criteria for an ICF/IDD, and if so, is at risk of placement without home and community based waiver services.
At the on-site review, CWP program staff review all documentation to assure the QIDP used the prescribed processes and correctly documented LOC determinations.
Regarding timely reevaluation of LOC: The PIHP and the CWP track due-dates for each consumer's LOC reevaluation. When MDHHS does not receive a timely waiver recertification from the PIHP, a reminder letter, call or Email is sent to the PIHP requesting the documentation.
If, in the course of MDHHS-CWP staff review of documentation for any purpose (e.g. quarterly review of consumers with the highest needs, initial or annual recertification, or request for special equipment or home modifications) a question about LOC arises, a Disposition Transmittal (DT) is used by CWP staff to identify questions or issues that must be addressed by the PIHP. The CMHSP must respond within 30 days of issuance of the DT. The response is reviewed by the MDHHS staff person who issued the DT to determine that appropriate action was taken and if any additional follow-up is necessary. (Such follow-up might include a visit to the consumer's home or request for additional information.)

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

MDHHS-CWP staff send a Disposition Transmittal (DT) or other form of communication to the PIHP to identify questions or issues that must be addressed regarding individual LOC determinations. The PIHP must respond within 30 days. The response is reviewed by the CWP staff to determine that appropriate action was taken and if any additional follow-up is necessary. This follow-up might include a visit to the consumer's home or request for additional information. A less formal, but documented, method of communication is through Email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to Emails are expected within 1-2 business days.
During on-site reviews, a sample of clinical records is reviewed, including all assessments and documentation that underpin the waiver certification level of care determination. Potential problems with level of care evaluation/re-evaluation may be identified during these annual site reviews, and are documented by MDHHS staff using the Site Review Protocol. The PIHP is required to respond to MDHHS's site review report within 30 days of receipt of the report with a plan of correction. This plan of correction must be reviewed and approved by MDHHS staff that completed the site review and by MDHHS administration. The remediation process continues until all concerns have been appropriately addressed. MDHHS-BHDDA maintains a log to track individual problems and their remediation.
Regarding timely reevaluation of LOC: If – despite reminder notices to the MDHHS-BHDDA does not receive a timely waiver recertification, a call is made to the case manager and his/her supervisor requesting information as to why the recertification has not been completed. If it is the agency that is responsible for the delay, the agency is informed they must provide the certification to MDHHS within 10 works days of the call. If needed, this call is followed-up by a letter to the PIHP Director stressing the urgency of a timely recertification and requesting immediate response as to the reason for non-compliance with the requirement for recertification. If the delay is due to the family not following through with the recertification process, the PIHP is required to inform the family that because the recertification is past due, the child's eligibility for the CWP is at risk and the recert must be completed within 10 working days to maintain eligibility. If the family subsequently does not cooperate with the recertification, the PIHP will issue a termination notice to the family, including their right to a Medicaid Fair Hearing. The PIHP must continue to provide services until one of three things occurs: 1) the family files a Request for Fair Hearing within 12 days of issuance of the letter and a Decision and Order is issued upholding the Department, 2) the legal representative indicates in writing they wish to withdraw their child from the waiver, or 3) the recertification is received within five working days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

When a child is invited to apply for the CWP (pursuant to the process described in B-3-f, above), the QIDP contacts the family to begin the formal application process. One of the first steps in this process includes meeting with the family to explain the process and timelines related to the waiver application, options and choices afforded the child/family, and rights and responsibilities associated with eligibility for the waiver. While the PIHP's QIDP is responsible for assuring and documenting several aspects of the application process (e.g., securing necessary signatures on the Waiver Certification Form), the child's parent/guardian representative is encouraged to invite others to participate as a natural support or as a facilitator.
An essential feature of the application process includes discussion with the family (and provision of information) about services and supports available under the waiver, and the family's right to choose among an array of qualified providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements for each service/support needed by their child. The purpose of these discussions and information-sharing is to enable the family to make an informed decision about choosing home and community-based waiver services as an alternative to institutional care.
Section 3 of the Waiver Certification form is used to document the parent/guardian was informed of their right to choose between community-based services provided by the CWP and ICF/IDD placement/services. Section 3 also documents the parent/guardian was informed of their right to choose among qualified service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangement.
The Waiver Certification form is maintained in the child's clinical record at the PIHP, and in the child's MDHHS case file. All aspects of choice are discussed with the child's family at the time of initial certification for the waiver. Choices (relative to home and community-based services over institutional services and to direct service providers) typically are discussed each time the child's plan of care is reviewed (which may be as frequent as monthly). MDHHS CWP staff confirms completion of Section 3 of the Waiver Certification Form at the time of initial certification for the CWP and at the time of annual recertification for the CWP. During on-site reviews, the State reviews the PIHP's policy / procedures related to offering/assuring informed choice of qualified providers as describe above and of waiver services in lieu of institutional services.

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

As stated above, Freedom of Choice is part of the Waiver Certification form and is maintained by the PIHP in the consumer's clinical record and by MDHHS in the consumer's record.

Appendix B: Participant Access and Eligibility

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

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

The contract between MDHHS and PIHPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. Each PIHP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHPS access system.
Access system services must be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. The PIHP must arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals. Telephone lines must be toll-free and accommodate people with Limited English Proficiency (LEP) and other linguistic needs, as well as be accessible for individuals with hearing impairments and must accommodate persons with diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.
The State's contract with PIHPs requires that PHIPs comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency. The contract addresses access to services by “limited English proficient persons” throughout the contract. Requirements include: equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance in the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency; that materials are written at the 4th grade reading level to the extent possible; and that materials shall be available in the languages appropriate to the people served within the PIHP's area.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Overnight Health and Safety Support**		
Statutory Service	**Respite**		
Extended State Plan Service	**Enhanced Transportation**		
Supports for Participant Direction	**Fiscal Intermediary**		
Other Service	**Community Living Supports**		
Other Service	**Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies**		
Other Service	**Home Care Training, Family**		
Other Service	**Home Care Training, Non-Family**		
Other Service	**Specialty Service**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Overnight Health and Safety Support

HCBS Taxonomy:

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

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

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

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

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Overnight Health and Safety Support is defined as the need for someone to be present to prevent, oversee, manage, direct, or respond to a beneficiary's disruptive, risky, or harmful behaviors, during the overnight hours. Overnight Health and Safety Support is indicated for a person who is non-self-directing, confused, has a cognitive impairment or whose physical functioning is such that they are unable to respond appropriately in an emergency. It is further indicated for beneficiaries who have inconsistency in, or an inability to, regulate sleep patterns.
For purposes of this service, "overnight" includes the hours between 8:00 p.m. and 8:00 a.m.
Overnight Health and Safety Support may be appropriate when:
- Service is necessary to safeguard against injury, hazard, or accident
- Service will allow recipient to remain at home safely after all other available preventive interventions have been undertaken, and the risk of injury, hazard or accident remains
- Assistance is needed with instrumental activities of daily living (IADLs) that cannot be pre-planned or scheduled

The following exceptions apply for Overnight Health and Safety Support:
- It does not include friendly visiting or other social activities.
- Is not available when the need is caused by a medical condition and the form of supervision required is medical.
- Is not available in anticipation of a medical emergency.
- Is not available to prevent or control anti-social or aggressive recipient behavior.
- Is not available for a person without a physical, cognitive, or memory impairment who has anxiety about being alone at night
- Is not an alternative to inpatient psychiatric treatment and is not available to prevent potential suicide or other self-harm behaviors.

The need for Overnight Health and Safety Support must be reviewed and established through the person centered planning process with the specific reasons for this service and what support activities will be provided.

If the participant receiving Overnight Health and Safety Support demonstrates the need for CLS or Respite, the IPOS must document coordination of services to assure no duplication of services provision with Overnight Health and Safety Support.

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

Payments for Health and Safety Support may not be made, directly or indirectly to responsible relatives (i.e., spouses or parents or minor children) or the legal guardian.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home care agency, staff agency and other PIHP contracted providers.
Individual	Aide

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Overnight Health and Safety Support

Provider Category:

Agency

Provider Type:

Home care agency, staff agency and other PIHP contracted providers.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or be contracted by the PIHP to provide CLS services to CWP consumers.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the PIHP meets the qualifications when the PIHP is the direct service provider. The CMHSP is responsible for verification of qualifications of agency providers with which it contracts. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

PIHPS and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Overnight Health and Safety Support

Provider Category:

Individual

Provider Type:

Aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The person must have the following qualifications:

- At least 18 years of age.
- Be able to practice universal precaution and infection control techniques.
- In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien).
- Be trained in recipient rights.
- Able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence.
- Able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence.
- Has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

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

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

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Respite care can be provided in the following locations: the child's home; licensed family foster home; licensed family group home; licensed childrens camp; licensed respite care facility approved by the State that is not a private residence; home of a friend or relative.

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

Nurses may provide respite only in situations where the consumer's medical needs are such that a trained respite aide cannot care for the consumer during times where the unpaid caregiver is requesting respite.

Beginning January 2012, families may schedule and use up to 1152 hours of respite service per fiscal year, in accordance with the consumer's IPOS. (The billable procedure code for respite is a 15-minute unit, which equates to a maximum respite benefit of 4,608 units per fiscal year.)

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Care Facility; Children's Camp; Foster Family Home; Foster Family Group Home
Individual	aide-level respite provider
Individual	Independent Nurse (RN or LPN)
Agency	PIHP or an agency contracted to the CMHSP

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Respite Care Facility; Children's Camp; Foster Family Home; Foster Family Group Home

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

The identified provider types must be contracted to the PIHP for the purpose of providing respite care services for CWP consumers.

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

If the agency is providing respite rendered by a nurse, in addition to the above qualifications, the the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Michigan Department of Health and Human Services (MDHHS) is the licensing authority and is responsible for issuing and renewing licenses for these providers. MDHHS also verifies provider qualifications during regular and special investigation visits.

The PIHP is responsible for verifying provider qualifications prior to contracting with the provider. The Respite Care Facility, Children's Camp, Foster Family Home or Foster Family Group Home is responsible for assuring that all employees providing this service meet the provider qualifications as identified in "other standard", above.

Frequency of Verification:

Licenses are issued/renewed for a two-year period. PIHPs and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

aide-level respite provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

Individuals providing respite must be hired through Choice Voucher arrangements or be independent contractors of the PIHP.
The person must have the following qualifications:

- At least 18 years of age.
- Be able to practice universal precaution and infection control techniques.
- In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien).
- Be trained in recipient rights.
- Able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence.
- Able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence.
- Has received training in the beneficiary’s IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Nurse (RN or LPN)

Provider Qualifications

License *(specify):*

When respite is provided by a nurse, the nurse must be either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) working under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211.

Certificate *(specify):*

NA

Other Standard *(specify):*

Individuals providing respite must be hired through Choice Voucher arrangements or be independent contractors of the PIHP. RN and LPN respite providers must meet criteria specified in the Michigan Medicaid Provider Manual: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow the consumer's individual plan of service (IPOS) and consumer-specific emergency procedures; have a documented understanding and skill in implementing the IPOS and report on activities performed; be in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, and not an illegal alien); be trained in recipient rights; be able to perform basic first aid and emergency procedures; and be trained in the IPOS, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At onset of service with an individual consumer, and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

PIHP or an agency contracted to the CMHSP

Provider Qualifications

License *(specify):*

If respite is provided by an agency nurse, either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN - the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211.

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or the agency must be contracted by the CMHSP to provide respite services to CWP consumers.

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

If the agency is providing respite rendered by a nurse, in addition to the above qualifications, the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211.

Verification of Provider Qualifications

Entity Responsible for Verification:

MMHHS verifies that the PIHP meets the qualifications when the PIHP is the direct service provider. The PIHP is responsible for verification of qualifications of agency providers with which it contracts. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the PIHP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

PIHPs and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Enhanced Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Enhanced transportation is offered in order to enable the child served on the Children's Waiver Program (CWP) to gain access to waiver and other community services, activities and resources specified by the child's individual plan of service (IPOS). This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. For purposes of this waiver, transportation is subject to what is reasonable and cost-effective, and limited to local destinations. Local is defined as destinations within the childs county of residence or a bordering county. Parents / guardians of a child on the CWP cannot be reimbursed or otherwise paid to provide this service for their child. Enhanced transportation is a reimburseable waiver service only when provided by trained respite staff or professional staff who have been trained in the child's IPOS and are currently working with the child.

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

Transportation is limited to local distances, where local is defined as within the childs county or a bordering county.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP
Individual	respite staff, clinical/professional service providers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PIHP

Provider Qualifications

License *(specify):*

Current Michigan Driver's license.

Certificate *(specify):*

Other Standard *(specify):*

This service can only be provided by respite staff or professional staff who are identified in the child's IPOS and are providing services at the time Enhanced Transportation is billed. In addition to possessing a current Michigan Driver's license, providers must also meet qualifications for the specific service they are provider during the time Enhanced Transportation is billed (e.g.; respite, recreational therapy, speech therapy).

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the PIHP meets the qualifications when the PIHP is the direct service provider. The PIHP must verify qualifications of individual providers. If Enhanced Transportation is provided by respite or professional staff, hired or contracted by the CWP consumer's representative through a Choice Voucher arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the Fiscal Intermediary.

Frequency of Verification:

PIHPs and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

respite staff, clinical/professional service providers

Provider Qualifications

License *(specify):*

current Michigan's Driver's license

Certificate *(specify):*

NA

Other Standard *(specify):*

This service can only be provided by respite staff or professional staff who are identified in the child's IPOS and providing services at the time enhanced transportation is billed. In addition to possessing a current Michigan Driver's License, providers must also meet qualifications for the specific service they are providing during the time enhanced transportation is billed (e.g., respite, recreational therapy, speech therapy).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP must verify provider qualifications. If enhanced transportation is provided by respite or professional staff hired or contracted by the CWP-consumer's representative through a Choice Voucher arrangement, the CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer and as applicable to the qualification therafter: Driver's licenses are issued for a five-year period; qualifications for service providers are verified every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Fiscal Intermediary

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A fiscal intermediary is an independent legal entity that acts as the fiscal agent of the CMHSP for the purpose of assuring financial accountability for the funds authorized to purchase the services and supports identified in the consumer's plan of service. The fiscal intermediary receives the funds; makes payments authorized by the consumer's representative to providers of services and supports; and acts as an employer agent when the consumer's representative directly employs staff or other service providers.

Fiscal intermediary services include, but are not limited to:
a) Facilitation of the employment of service workers by the child's parent or guardian, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
b) Assuring adherence to federal and state laws and regulations; and
c) Ensuring compliance with documentation requirements related to management of public funds.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Intermediary Agency
Individual	Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications stated below

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Fiscal Intermediary

Provider Category:

Agency

Provider Type:

Fiscal Intermediary Agency

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHSP is responsible for verification of qualifications of agency providers with whom it contracts. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the CMHSP's panel of providers and during routine monitoring of providers.

Frequency of Verification:

CMHSPs verify that providers meet qualifications prior to delivery of services and at least annually thereafter.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Fiscal Intermediary

Provider Category:
Individual
Provider Type:

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

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The individual must be contracted by the CMHSP to provide financial management services to CWP consumers. Additional qualifications include that the fiscal intermediary:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The CMHSP is responsible for verification of qualifications of individual providers with whom it contracts. The CMHSP verifies provider qualifications before contracting with individuals and adding them to the CMHSP's panel of providers and during routine monitoring of providers.

Frequency of Verification:

CMHSPs verify that providers meet qualifications prior to delivery of services and at least annualy thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the childs independence and integration into the community. Children on the CWP have high intensity and frequency of care needs and, as eligibility for the CWP requires the ICF/MR LOC, children must receive a continuous active treatment program. For children who receive CLS, staffing allows for the "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services" referenced in the definition of active treatment. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to the child. The supports, as identified in the individual plan of services, are provided in the childs home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

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

The amount of CLS that is billable for each consumer is based on assessed needs as documented in the narrative for the consumer's "Category-of-Care" (described further in Appendix D) and the accompanying "Decision Guide", as published in the Michigan Medicaid Provider Manual.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP or an agency contracted to the PIHP for the purpose of providing CLS services for CWP consumers (e.g., staffing agency, home care agency)
Individual	CLS aide

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

PIHP or an agency contracted to the PIHP for the purpose of providing CLS services for CWP consumers (e.g., staffing agency, home care agency)

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a CMHSP or be contracted by the CMHSP to provide CLS services to CWP consumers.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the PIHP meets the qualifications when the PIHP is the direct service provider. The PIHP is responsible for verification of qualifications of agency providers with which it contracts. The PIHP verifies provider qualifications before contracting with agencies and adding them to the PIHP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

PIHPs and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Individual

Provider Type:

CLS aide

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

Individuals providing Community Living Supports (CLS) must be hired through Choice Voucher arrangements or be independent contractors of the CMHSP.
The person must have the following qualifications:

- At least 18 years of age.
- Be able to practice universal precaution and infection control techniques.
- In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien).
- Be trained in recipient rights.
- Able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence.
- Able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence.
- Has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the PIHP meets qualifications when the PIHP is the direct service provider. The PIHP verifies provider qualifications. If the CWP-enrollee's representative hires the individual directly through a Choice Voucher arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies

HCBS Taxonomy:

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

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

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services (IPOS), which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must first be denied by all applicable insurance sources, e.g., private insurance and Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.

Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes.

The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDDHS are not obligated for any restoration costs. If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations.

The CWP does not cover construction costs in a new home or addition, or a home purchased after the consumer is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased. Additional square footage may be prior authorized following a MDHHS specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's record.

Specialized Medical Equipment & Supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's IPOS. This service is intended to enable the child to increase his abilities to perform ADLs or to perceive, control, or communicate with the environment in which the child lives.

This service also includes van lifts, wheelchair tie-downs or if appropriate, a secure seating device that would substitute for the wheelchair. Vehicle modifications are covered only as necessary to the extent needed to accommodate lifts, wheelchair tie-downs, or secure seating devices that would substitute for the wheelchair. Specialized medical equipment and supplies also includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non- durable medical equipment not covered by Medicaid or through other insurance. Generators may be covered for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator.

Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's IPOS. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented. Training of staff and care-givers is a covered waiver service and includes training on specialized equipment.

A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the IPOS. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards.

Anything purchased under this service category must meet applicable standards of manufacture, design and installation. The PIHP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase. When a warranty is not purchased but the item requires repair that does not arise from mis-use, failure to maintain the item in good working order or abuse of the item, the repair can be covered by the waiver. The cost of routine maintenance and general upkeep is not included as a waiver service and is considered the responsibility of the consumer's family. As used in this definition, "routine maintenance and general upkeep" includes any task, activity, product or supply required to keep the equipment, supply, adaptation, device or anything purchased under this service in good working order; and is distinguished from "repair" of a broken or non-functioning item.

Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's IPOS. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented. Training of staff and care-givers is a covered waiver service and includes training on specialized equipment.

A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the IPOS. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards.

Anything purchased under this service category must meet applicable standards of manufacture, design and installation. The PIHP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase. When a warranty is not purchased but the item requires repair that does not arise from mis-use, failure to maintain the item in good working order or abuse of the item, the repair can be covered by the waiver. The cost of routine maintenance and general upkeep is not included as a waiver service and is considered the responsibility of the consumer's family. As used in this definition, "routine maintenance and general upkeep" includes any task, activity, product or supply required to keep the equipment, supply, adaptation, device or anything purchased under this service in good working order; and is distinguished from "repair" of a broken or non-functioning item.

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

The cost of routine maintenance and general upkeep is not included as a waiver service and is considered the responsibility of the consumer's family. As used in this definition, "routine maintenance and general upkeep" includes any task, activity, product or supply required to keep the equipment, supply, adaptation, device or anything purchased under this service in good working order; and is distinguished from "repair" of a broken or non-functioning item.

Environmental Accessibility Adaptations that add to the total square footage of the home are limited to a lifetime maximum of $25,000 and/or 250 square feet, with an exception process in place for extraordinary circumstances.

Specialized Medical Equipment & Supplies: The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

A van lift for a full size van will be considered no more frequently than once every five years, which is the minimum life expectancy of a van lift. All van modifications or installations must be to a van that is the consumer's primary means of transportation. This service excludes the purchase or lease of a van and the upkeep and maintenance of the van.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Builder or Contractor
Agency	PIHP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies

Provider Category:
Individual
Provider Type:

Licensed Builder or Contractor

Provider Qualifications

License *(specify):*

Holds current Michigan license under MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3)

Certificate *(specify):*

NA

Other Standard *(specify):*

NA

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to initiation of service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies

Provider Category:

Agency

Provider Type:

PIHP

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The PIHP is the provider. All items purchased by the PIHP under this service under this service must meet applicable standards of manufacture, design and installation. The PIHP must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards)was obtained for the item at the time of purchase.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the CMHSP meets the qualifications when the CMHSP is the direct service provider.

Frequency of Verification:

Prior to contracting with the provider for the item.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Care Training, Family

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Home Care Training, Family is also a counseling service directed to the family and designed to improve and develop the familys skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the childs individual plan of services and must be provided on a face-to-face basis.

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

Up to four sessions per day but no more than 12 sessions per 90 day period. This service does not include the costs of travel, meals and overnight lodging associated with training.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHPS; agencies contracted to PIHPs (e.g., home care agencies, clinical service agency providers, out-patient clinics)
Individual	Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Training, Family

Provider Category:

Agency

Provider Type:

PIHPS; agencies contracted to PIHPs (e.g., home care agencies, clinical service agency providers, out-patient clinics)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

The hands-on service provider must be either a licensed psychologist, Master's level social worker, or who is a Qualified Intellectual Disability Professional(QIDP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the CMHSP meets the qualifications when the PIHP is the direct service provider. The CMHSP is responsible for verification of qualifications of agency providers with which it contracts. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the PIHP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

PIHPS and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Training, Family

Provider Category:

Individual

Provider Type:

Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

Service providers for Home Care Training, Family must be either a licensed psychologist, Master's level social worker, or who is a Qualified Intellectual Disability Professional(QIDP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHPS verifies provider qualifications. If the CWP-enrollee's representative contracts with the individual directly through a Choice Voucher arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Care Training, Non-Family

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service provides coaching, supervision and monitoring of Community Living Support (CLS) and respite staff by clinical professional (psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse, or (QIDP). The professional staff work with CLS staff to implement the plan that addresses services designed to improve the childs social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage. Professional staff train, supervise and monitor CLS staff to ensure appropriateness of service delivery and continuity of care.

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

Up to four sessions per day but no more than 12 sessions per 90 day period.

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)
Agency	PIHPS; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency providers, out-patient clinics)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Training, Non-Family

Provider Category:

Individual

Provider Type:

Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

Service providers for Home Care Training, Non-Family must be either a licensed psychologist, Master's level social worker, or who is a Qualified Intellectual Disability Professional(QIDP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the CWP-enrollee's representative contracts with the individual directly through a Choice Voucher arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Care Training, Non-Family

Provider Category:

Agency

Provider Type:

PIHPS; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency providers, out-patient clinics)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

The hands-on service provider must be either a licensed psychologist, Master's level social worker, or Qualified Intellectual Disability Professional(QIDP), as defined in CFR 483.430. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the PIHP meets the qualifications when the CMHSP is the direct service provider. The CMHSP is responsible for verification of qualifications of agency providers with which it contracts. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the PIHP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

PIHPS and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialty Service

HCBS Taxonomy:

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

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

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

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialty Services include: Music Therapies; Recreation Therapies; Art Therapies; and Massage Therapies. Specialty services uses treatment, education, and therapeutic activities to help children with disabilities to develop skills and abilities that enhance their health, functional ability, independence and quality of life. Observation of and participation by parents and staff of these therapeutic activities help teach parents and staff to work with the child and provides continuity to further the objectives of the therapeutic sessions. These therapies may be used in addition to the traditional professional therapy models covered under Medicaid State Plan. Services must be directly related to an identified goal in the individual plan of service and approved by the physician.

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

Services are limited to four sessions per therapy per month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist
Agency	PIHPS; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency providers, out-patient clinics)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialty Service

Provider Category:
Individual
Provider Type:

Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist

Provider Qualifications
License *(specify):*

Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008.

Certificate *(specify):*

Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); Art Therapist must be a Registered Art Therapist (ATR); Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB).

Other Standard *(specify):*

Individuals must be hired through Choice Voucher arrangements or be independent contractors of the CMHSP.

Verification of Provider Qualifications
Entity Responsible for Verification:

The CMHSP verifies provider qualifications. If the CWP-enrollee's representative contracts with the individual directly through a Choice Voucher arrangement, the CMHSP may delegate the responsibility for verifying provider qualifications to the fiscal intermediary.

Frequency of Verification:

At the onset of service for an individual consumer, and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialty Service

Provider Category:
Agency
Provider Type:

PIHPS; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency providers, out-patient clinics)

Provider Qualifications
License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008. A Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); Art Therapist must be a Registered Art Therapist (ATR); Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB).

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies that the PIHP meets the qualifications when the CMHSP is the direct service provider. The PIHP is responsible for verification of qualifications of agency providers with whom it contracts. The CMHSP verifies provider qualifications before contracting with agencies and adding them to the PIHP's panel of providers and during routine monitoring of providers. The agency is responsible for assuring that all staff providing this service meet provider qualifications.

Frequency of Verification:

PIHPs and contracted agencies verify that individual service providers meet qualifications prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

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

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

The PIHPs or their contracting agency are responsible for conducting case management functions and for the coordination of waiver services on behalf of waiver consumers. Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) and have: A minimum of a Bachelor's degree in a human services field; and one year of experience working with people with developmental disabilities.

Appendix C: Participant Services

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

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

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

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

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

(a) Criminal history/background investigations are completed for all direct care aide-level staff, all clinicians and all other individuals providing waiver services – whether a contractor or an employee. PIHPs and entities/individuals assisting consumers using Choice Voucher arrangements perform the investigations prior to hiring aides to perform respite and CLS services and/or prior to contracting with clinical service providers.

(b) The PIHP or its contracted provider agency is responsible for completing the criminal history/background investigation by checking statewide databases (e.g., Law Enforcement Information Network, the State's Child Abuse and Neglect Central Registry.) These checks are used to assess the good moral character and suitability of those who interact with campers and for providing documentation in the employee's personnel file. The Federal Compliance site reviews are the mechanisms for ensuring the background checks are completed.

(c)The Michigan Medicaid Provider Manual and the Michigan Mental Health Code state that staff must be in good standing with the law. The definition of "be in good standing with the law" means the person is not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

◉ **No. The state does not conduct abuse registry screening.**

○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Children's Camp; Foster Family Home; Foster Family Group Home; Respite care facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Only respite services are provided outside the child's home. The annual maximum amount of respite is 14 days or 4 days per month. In other words, the facilities children receive respite in are never intended to house them long term. While in respite, children continue to go to school or participate in the community in the same way they would at home.

One of 4 provider types that can provide respite (foster family homes) is "home like" given the definition and the nature of the provider type. Another of the provider types, Children's Camps, are not home like given their nature and their intended function. The remaining 2 provider types, Respite care facilities and foster family group homes, can serve a maximum of 13 children and while those children are receiving respite, they will continue in all of the community based activities they would if they were at home.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Children's Camp; Foster Family Home; Foster Family Group Home; Respite care facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Fiscal Intermediary	☐
Enhanced Transportation	☐
Community Living Supports	☐
Overnight Health and Safety Support	☐
Home Care Training, Non-Family	☐
Respite	☒
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	☐
Specialty Service	☐

Waiver Service	Provided in Facility
Home Care Training, Family	☐

Facility Capacity Limit:

Children's Camp (no maximum but required staffing ratio); Foster Family Home (for or fewer minor children): Foster Family Group Home and Respite Care Facility (maximum 13 minor children)

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **Self-directed**

☐ **Agency-operated**

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

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

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

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

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

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

◉ **Other policy.**

Specify:

Michigan does not allow payment to legal guardians or to relatives who are legally responsible for providing services to the child. Subject to this qualification other relatives may be paid if they meet all provider qualifications. Services provided by relatives meeting these criteria are subject to the same claim processing edits (including quantity parameters) as services provided by non-relatives.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Children's Waiver operates concurrently with the State's §1115 managed care authority. The enrollment of providers is governed under the provisions of the MDHHS/PIHP Managed Specialty Supports and Service contract, which were derived from 42 CFR §438.207. PIHPs are required to maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs/assure services and supports provision consistent with the plans of services of their participants, and to include participant-requested providers on their enrolled provider panels when they meet the PIHPs qualifications, cost, and reasonable accommodation parameters.

MDHHS/PIHP Managed Specialty Supports and Service contract:
7.0 provider network services
7.1 provider credentialing
37.0 provider procurement
attachment P 7.1.1 credentialing and re-credentialing processes
https://www.michigan.gov/documents/mdch/FY09-10MAContractwithallattachments_312218_7.pdf

Medicaid Provider Manual (Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter >> Section 14 CWP) https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes:
https://www.michigan.gov/documents/mdhhs/PIHP-MHSP_Provider_Qualifications_530980_7.pdf

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of applicants for provision of CWP services that meet initial credentialing standards prior to provider enrollment. Numerator: Number of applicants for provision of CWP services that meet initial credentialing standards prior to provider enrollment. Denominator: All new provider applicants for provision of CWP services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☒ **Other** Specify: biennial, statewide data gathered over a 2-year time period	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of providers of CWP services that continue to meet credentialing standards. Numerator: Number of providers of CWP services that continue to meet credentialing standards. Denominator: All providers of CWP services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year time period	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:

Number and percent of non-licensed, non-certified waiver service providers that meet provider qualifications as stated in the Michigan Medicaid Provider Manual. Numerator: Number of non-licensed, non-certified waiver providers that meet qualifications. Denominator: All non-licensed, non-certified waiver providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percent of waiver providers that meet staff training requirements. Numerator: Number of waiver service providers that meet staff training requirements. Denominator: All waiver providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

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

The biennial Federal Compliance Section site reviews verify that the PIHPs have documentation that all providers meet provider qualifications and have completed training as required by policy, as published in the Michigan Medicaid Provider Manual. These reviews include looking at credentials and qualifications of a sample of providers, discussions with PIHP staff, review of administrative policies and procedures, training, clinical record reviews, interviews with service recipients, and visits to some programs and residential sites.

b. Methods for Remediation/Fixing Individual Problems

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

Any findings noted during the site review process are included in a formal report issued by the MDHHS-BHDDA to the PIHP. If an urgent or immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP will be required within 48 hours. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. MDHHS-BHDDA maintains a log to track individual problems and their remediation. Members of the Site Review Teams review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDHHS-BHDDA CWP staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDHHS. In addition to the full site review, the Federal Compliance Section Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. All children and youth enrolled in the CWP are living in their family home.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Plan of Service (IPOS)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

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

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS-BHDDA/PIHP contract, MDHHS-BHDDA delegates the responsibility for service plan development for children in the CWP to the PIHPs. PIHPs and their subcontractors may provide direct waiver services. The development of the plan through the person-centered planning (PCP) process (which for children is the family-guided/youth driven planning process) is led by the child (as appropriate, given the child's age) and family with the involvement of allies chosen by the family to ensure that the service plan development is conducted in the best interests of the child. The consumer has the option of choosing an independent facilitator (not employed by or affiliated with the PIHP) to facilitate the planning process. In addition, the PIHP, through its Customer Services Handbook and the one-on-one involvement of a case manager or other person chosen by the consumer/family is required to provide full information and disclosure to consumers about the array of services and supports available and that consumers have choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements. The consumer has the option to choose his or her case manager employed by a PIHP (or to choose another qualified entity). This range of flexible options enables the family to identify who he or she wants to assist with service plan development that meets the family's interests and needs. Person-centered planning is one of the areas addressed during biennial Federal Compliance Section/CWP Site Reviews of each PIHP. The case manager can not authorize services. The PIHP authorizes services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Michigan uses a Person-Centered Planning (PCP) process mandated by law. “PCP means a process for planning and supporting the individual receiving services that builds upon the individuals capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities” MCL 330.1700(g). The PCP planning process: 1) focuses on the individual’s life goals, interests, desires, preferences, strengths and abilities as the foundation for planning process; 2) identifies outcomes based on the individual’s life goals, interests, desires and preferences; 3) makes plans for the individual to work toward and achieve identified outcomes; 4) determines the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system; and 5) develops an Individual Plan of Service (IPOS) that directs the provision of supports and services to be provided through the Prepaid Inpatient Health Plans (PIHP).
Meaningful PCP is at the heart of supporting consumer choice and control. This includes that the consumer is encouraged to identify individuals they wish to participate in pre-planning and formal planning events; and to invite those individuals to all planning meetings. As needed, the consumer, his/her parent/guardian and other individuals participating in planning and developing the IPOS, receive comprehensive and unbiased information on the array of mental health services, community resources and supports, and available qualified providers. Consumers are also asked if there are other supports or accommodations needed to enable them to meaningfully participate in the process. If so, these are documented and provided. PCP planning focuses on the goals, interests, desires and preferences of the individual, while still exploring and addressing an individual’s needs within an array of
established life domains (including, but not limited to those listed in the Michigan Mental Health Code: the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). PCP focuses on services and supports necessary for the individual to work toward and achieve their personal goals rather than being limited to authorizing the individual to receive existing programs.
(b)For children, the concepts of person-centered planning are incorporated into a family driven, youth-guided approach. A family-driven, youth-guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

While a case manager or other qualified provider chosen by the consumer/family may coordinate and facilitate development of the IPOS, the consumer/family have choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements services identified in the IPOS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Michigan uses a Person-Centered Planning (PCP) approach in the development of the individual plan of service (IPOS). For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The family is the constant throughout the life of their child, while fluctuations occur at the service system level due to personnel changes and turnover. The PCP process is an individualized, needs-driven, strengths based process for children and families with multiple needs. The planning process begins prior to the application for the Children's Waiver Program (CWP). A preliminary plan must be developed within seven days of commencement of services [MCL 330.1712 (Michigan Mental Health Code)]. Consistent with Michigan's strong focus on a family-driven/youth-guided service planning process, all meetings are scheduled at times and locations convenient to the child and family, and for others identified by the consumer/family to participate in planning.

b) The consumer's needs, preferences, goals, and health status are determined through pre-planning and the PCP process. This process results in an IPOS as identified in (a) above. Therefore, no "standard" assessment is necessary or required prior to the onset of services. Just as the IPOS is individualized, so too are the assessments. Most often, a psychosocial assessment is completed; depending on the individual consumer, other assessments may be needed to determine functional eligibility for specific services and supports. These include, but are not limited to: psychological, behavioral, psycho/social, speech, occupational and/or physical therapy, social/recreational, and medical evaluations. The IPOS is a dynamic document that is revised based on changing needs, newly-identified or developed strengths and/or the result of periodic reviews and/or assessments. The child's team includes those persons most familiar with the child and family, plus service providers. The majority of team members are the parents plus family members, friends and neighbors selected by the family. The functions of the PCP team include: 1)focus on the individual’s life goals, interests, desires, preferences, strengths and abilities as the foundation for planning process; 2) identification of outcomes based on the individual’s life goals, interests, desires and preferences; 3) making plans for the individual to work toward and achieve identified outcomes; 4) determining the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system; and 5) developing an IPOS that directs the provision of supports and services to be provided through the Prepaid Inpatient Health Plans (PIHPs).
c) Once the needs of a child are identified through assessments, the family is informed of available services and that consumers have choice among service providers who are on contract with or employed by the CMHSP or hired through Choice Voucher arrangements to respond to the child's identified needs. This can be accomplished through several methods. The case manager, or other qualified service provider chosen by the family, can review the list of waiver services with the child, family and team. CWP services are also identified in the Michigan Medicaid Provider Manual.
d) Each PCP Team ensures that the plan is family-driven, not agency driven, and that it includes planning across all life domains, including: emotional, psychological and behavioral health; health, education/vocational needs; financial and other resources; cultural and spiritual needs; crisis and safety planning; housing and home; meaningful relationships and attachments; legal issues and planning; daily living; family; social, recreational and community inclusion; and other life domains, as determined by the consumer/family and the PCP Team.
e) The IPOS must address the coordination and oversight of any identified medical care needs to ensure health and safety. This includes areas of concern such as drug / medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or coexisting general medical conditions requiring care.
f) Life Domain planning is always a blend of formal and informal resources. It uses strategies based on strengths, focused on need, and which are individualized and community-based. The IPOS identifies each of the interventions/responsibilities to be implemented, and who is responsible to implement or monitor the service.
g) The PCP Team develops the IPOS and provides on-going oversight, with the case manager or other qualified provider chosen by the consumer taking the lead responsibility. The Plan of Service must be updated at least annually, or as needed as the child's needs change; revisions must be reflected in the IPOS.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Although a child or youth participates in planning for services, as minors, they can not direct services or service providers. As noted above, all individual plans of care include crisis and/or safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The child, the family and/or the Child's Team define the "crisis". The Crisis Plan provides for around-the-clock response in the community (24 hours per day, 7 days per week) and includes a safety plan that is intended to insure the safety of the children or family members in the home.
The essential ingredients of crisis and safety plans include that the strengths, assets, interests are evident in plans; action steps to change and handle events or behavior are specified; proactive and reactive steps are identified; 24/7 response and support; long term sustainability; natural supports and community resources are used first; constant revision; documentation; strategies across environments; individualized strategies; and identification of whom to call based on skills.
The crisis plan is based on a careful review of the child's history to identify triggers of crisis. For example, a crisis might be brought on by new situations, a new route, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the child and family by community agencies, fears or worries expressed by the family, etc. For each identified crisis and safety concern both preventive and reactive strategies are identified and written into the IPOS. However, as with all aspects of the IPOS strategies are strength- based and grounded in the family's strengths and culture.
All children enrolled in the CWP are minors living with their birth or adoptive parents or with a legal guardian who is a relative who are ultimately responsible for the care and well being of their child. Waiver services include active treatment, training, and support to the child and relief for parents. The CWP standards include requirements that staffing meets the child's identified needs as outlined in the child's IPOS. Crisis and safety plans must identify when a child's well-being could be jeopardized when a care provider fails to show up or is unable to provide services. The IPOS must include a written plan for families to follow when issues such as provider no-shows arise; and the written plan must identify provisions for alternate arrangements for staffing services that are critical to child's well being. While the PIHP is ultimately responsible for assuring that services identified in the IPOS are provided at a level that meets the child's needs, this responsibility initially rests with the entity providing staff, as identified in the contract with the PIHP (e.g., contractual staffing agencies).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Michigan assures that each individual found eligible for the Children's Waiver Program (CWP) will be given choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements for each service included in his or her written Individual Plan of Service (IPOS). The case manager or other QIDP provides a consumer a list of providers from which to choose during the pre-planning process, the IPOS development process and whenever the IPOS is updated. Some PIHPs also post provider directories on the internet. At a practical level, once a child's needs are identified and prioritized, an IPOS is created. The IPOS is grounded in assessments of the child's needs and strengths, the family's culture and preferences, and strategies designed to meet the child's/family's identified needs/strengths/preferences. Options and strategies include, but are not limited to, waiver services.

The child and family choice drives the IPOS and selection of providers. Where waiver or Medicaid State plan services are the appropriate service response, the family can choose among any willing provider who is qualified to deliver the service. Providers can be: 1) employed by, or contracted to, the PIHP; or 2) hired through Choice Voucher arrangements. In the process of service plan development, these options are discussed with families when the IPOS is established and each time the IPOS is reviewed. If the family identifies a qualified provider who is not part of the PIHP's provider network, the PIHP will contact the provider to see if he/she is willing to contract with the PIHPP to provide services to the consumer; or - if the service is one that can be self-directed - to see if the provider is willing to provide services under the Choice Voucher System.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The responsibility for approving the individual plan of services (IPOS) is delegated to the PIHP. Each PIHP develops the process by which it approves the IPOS, but the plan must be developed in conformance with requirements as published in the Michigan Mental Health Code (ref: Section 330.1712, Individualized written plan of services).
The MDHHS Federal Compliance Section provides oversight through the site review process. A full site review is completed every other year, with a follow-up review on the alternate year. MDHHS CWP staff accompany the Federal Compliance staff on each full site review, completing an in-depth clinical record review using a standard review protocol for each case selected using a proportionate random sampling process. During the site review, IPOS are reviewed to ensure that the concepts of person-centered planning are incorporated into a family- driven, youth-guided approach and that the IPOS ensures the health and welfare of waiver consumers. Also during these full site reviews, Federal Compliance staff conduct the administrative review of the CWP records selected for clinical review. In alternate years, Federal Compliance staff conduct the follow-up review of CWP administrative and clinical records.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The PIHP is responsible for monitoring implementation of the Individual Plan of Service (IPOS) and for assuring that: 1) all health and safety issues and all risk management issues are addressed; 2) a Person-Centered Planning, family-driven/youth-guided approach is used to develop the IPOS; 3) parents/guardians were informed of choice of waiver services; and 4) parents/guardians were informed of their choice among service providers who are on contract with or employed by the PIHP or can be hired through Choice Voucher arrangements. The case manager, or other qualified provider selected by the child/family, is responsible for monitoring the provision of individual services and supports, as identified in the child's IPOS. The case manager, or other qualified provider selected by the child/family, must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the consumer. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the consumers health and welfare needs identified in the IPOS. The IPOS is reviewed as needed, but at least annually by the child/family and by the case manager, or other qualified provider selected by the child/family. Any revisions are reflected in the IPOS, and are part of the child's clinical record. The consumer's access to non-waiver services identified in the IPOS, including health care, are also monitored.

During the biennial Federal Compliance site review, when the site review team reviews a consumer's record they look for the following things: the IPOS addresses the consumer's assessed needs and identifies the services by type, amount, frequency and duration; the IPOS was developed in accordance with the Person-Centered Planning, family-driven/youth-guided principles; services were delivered in accordance with the IPOS; family satisfaction with services, including adequacy of back-up plans; and the parent/guardian was informed of their choice of waiver services and qualified providers.

Any findings noted during the site review process are included in a formal report issued by the MDHHS-BHDDA to the PIHP. If an immediate need (e.g.; a health and safety concern) for action is noted by the Site Review Team related to these assurances, a review and response within 48 hours by the PIHP may be required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDHHS-BHDDA CWP staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDHHS. In addition to the full site review, the MDHHS Federal Compliance Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

While the case manager and other clinical staff may directly provide some waiver services (e.g., family training), they do not provide “day-to-day” services (e.g., CLS, respite) nor do they conduct any activity that constitutes the direct delivery of underlying medical, education, social or other services to which a waiver consumer has been referred. The child's team, which includes parents, other family members, and family friends ensure that monitoring of the IPOS is conducted in the best interest of the waiver consumer. Per the Michigan Mental Health Code, the ultimate responsibility for monitoring implementation of the IPOS and participant health and welfare rests with the PIHPs. However, "first-level" monitoring is done by the case manager or other qualified entity or individual chosen by the consumer. The case manager's supervisor or another qualified QIDP at the PIHP provides "second-level" monitoring to assure the consumer's best interests prevail. No individual in the chain of monitoring responsibility directly delivers day-to-day services or enagages in any activity that constitutes the direct delivery of underlying medical, education, social or other services to which a waiver consumer has been referred.

At any time a consumer or his/her representative has any concern that services are not delivered in the best interest of the consumer, they have the right to request a local grievance review, file a complaint with Medicaid Fair Hearing or file a complaint with the local Recipient Rights Office. Additionally, contact information for CWP staff is on the MDHHS website. CWP staff are contacted regularly, by phone and email, by parents of children on the CWP with questions or concerns.

A thorough review of all aspects of the IPOS, including monitoring activities and consumer satisfaction with services, occurs during the biennial site review for a proportionate random sample of CWP records.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS includes services and supports that align with their assessed needs. Numerator: Number of enrolled consumers whose IPOS includes services and supports that align with their assessed needs. Denominator: All enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS reflects their goals and preferences. Numerator: Number of enrolled consumers whose IPOS reflects their goals and preferences. Denominator: All enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	Ongoing	Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS had adequate strategies to address their assessed health and safety risks. Numerator: Number of enrolled consumers whose IPOS had adequate strategies to address their assessed health and safety risks. Denominator: All enrolled consumers with identified health and safety risks.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of IPOS for enrolled consumers that are developed in accordance with policies and procedures established by MDHHS. Numerator: Number of IPOS for enrolled consumers that are developed in accordance with policies and procedures established by MDHHS. Denominator: All IPOS for enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS are updated within 365 days of their last plan of service. Numerator: Number of enrolled consumers whose IPOS were updated within 365 days of their last plan of service. Denominator: All enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS changed when the individual's needs changed. Numerator: Number of enrolled consumers whose IPOS was changed when the individual's needs changed. Denominator: All enrolled consumers whose needs changed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of IPOS for enrolled consumers in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency. Numerator: Number of IPOS for enrolled consumers with services and supports provided as specified in the plan, including type, amount, scope, duration and frequency. Denominator: All IPOS for enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of parents or legal guardians of enrolled consumers who are informed of their right to choose among the various waiver services. Numerator: Number of parents or legal guardians of enrolled consumers who are informed of their right to choose among the various waiver services. Denominator: All parents/guardians of enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of parents or legal guardians of waiver consumers who are offered the choice between CWP services and services in an ICF/IDD. Numerator: All parents or legal guardians of waiver consumers who are offered the choice between CWP services and services in an ICF/IDD. Denominator: All parents or legal

guardians of waiver consumers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers or through Choice Voucher arrangements. Num: Number of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers or through Choice Voucher arrangements. Den: All parents/guardians of enrolled consumers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide data gathered over a 2-year period	

Data Aggregation and Analysis:

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

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

When the Michigan Department of Health and Human Services Federal Compliance site review team reviews a consumer's record they look for the following things: the IPOS addresses the consumer's assessed needs and identifies the services by type, amount, frequency and duration; the IPOS was developed in accordance with the Person-Centered Planning, family-driven/youth-guided principles; and services were delivered in accordance with the IPOS. At the time the initial and annual waiver certification/recertification is submitted to MDHHS, it is reviewed to assure that the consumer's parent or guardian was informed of their choice of waiver services in lieu of institutional care and their choice that consumers have choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements.

b. Methods for Remediation/Fixing Individual Problems

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

Any findings noted during the site review process are included in a formal report issued by the MDHHS- BHDDA to the PIHP. If an immediate need for action is noted by the Federal Compliance Site Review Team e.g., services to address assessed needs are not included in the IPOS, the consumer's safety needs are not assessed or addressed, or services are not provided as specified in the IPOS), an immediate review and response by the PIHP within 48 hours is required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDHHS-BHDDA CWP staff within 90 days after the Remedial Action Plans/Plans of Correction has been approved by MDHHS. In addition to the full site review, the Federal Compliance Section Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.
In those instances were an immediate need for remedial action by the PIHP on behalf of an individual consumer (see examples in the above paragraph), that issue is addressed by CWP site review staff directly with the CWP case manager (or other qualified QIDP) and his/her supervisor to determine how to: 1) resolve the issue for that individual; 2) the time frame for remediation (which, depending on the issue, may be 1 - 4 weeks); and 3) provide any needed technical assistance or training at the local level.
Documentation of individual actions may be in the form of emails, fax transmittals, phone calls, training logs or visits to a CWP consumer's home.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Michigan has a long history of supporting opportunities for participant self-direction that goes back to the early 1990s. These opportunities were reinforced when, in 1996, the Michigan legislature made person-centered planning a requirement for all consumers receiving services and supports under the Mental Health Code. Since 1997 when Michigan was awarded its Robert Wood Johnson Self-Determination demonstration grant, the Michigan Department of Health and Human Services(MDHHS) has continued to build the demand and capacity for arrangements that support self-determination. Elements of participant direction are embedded in both policy and practice from Michigans Mental Health Code, the MDHHS Person-Centered Policy Practice Guideline and Self-Determination Policy and Practice Guideline, the requirements in the contracts between the state and the PIHPs, and technical assistance at the state level for multiple methods for implementation by PIHPs.

While the principles of self-determination apply only to adults, the methods for implementing such arrangements were incorporated into the Childrens Waiver Program (CWP), in 2002. That year, the first version of the Choice Voucher System Technical Advisory for the Childrens Waiver Program was released.

(a) The nature of the opportunities afforded to consumers

Through their representative, CWP consumers may elect employer authority or budget authority and can direct a single service or all of their services for which consumer direction is an option. Resources to support the chosen consumer-directed services are transferred to a fiscal intermediary (this is the Michigan term for the entity that provides Financial Management Services-FMS), which administers the funds and makes payment upon authorization of the consumers representative.

Consumers can directly employ staff or contract with clinical providers through Choice Voucher arrangements. The responsible parent of the CWP consumer is the common law employer of the providers of hourly care staff and directs clincial providers through purchase of service agreements. The responsible parent delegates performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The responsible parent of the CWP consumer directly recruits, hires and manages service providers. Detailed guidance to PIHP entities on the Choice Voucher System is provided in the Choice Voucher System Technical Advisory.

(b) How consumers may take advantage of these opportunities

The Customer Services Handbook, which includes information about self-directed services, is disseminated to all consumers of mental health services and is provided at the onset of services. Information on these arrangements is also provided by the case manager (or other QIDP selected by the family) to all CWP-enrolled consumers and their families – at initial enrollment and on an on-going basis. As used throughout the application, "other QIDP selected by the family" refers to the fact a consumer cannot be required to have a case manager. The other QIDP would be a PIHP employee assigned to complete the functions identified under the Targeted Case Management (TCM) service in the MA Provider Manual. The information is provided in the context of discussing options regarding waiver services and qualified providers. Parents of CWP consumers interested in pursuing arrangements that support self-direction begin the process by letting their case manager (or other QIDP) know of their wishes. Consumers/families are given information regarding the responsibilities, liabilities and benefits of consumer -direction prior to the person-centered planning process. An individual plan of service (IPOS) is developed through this process with the consumer and his/her family, case manager, and allies chosen by the consumer and his/her family. The plan includes services and supports needed by and appropriate for the consumer, and identifies the waiver services the consumer/family wishes to self-direct. An individual budget is developed based on all the services and supports identified in the IPOS, and must be sufficient to implement the IPOS. The responsible parent of the CWP consumer can choose to use the Choice Voucher System for the identified self-directed services.

c) The entities that support individuals who direct their services and the supports that they provide

Through its contract with MDHHS, each PIHP is required to offer information and education to consumers on consumer direction. Each PIHP also offers support to consumers and their families in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

While there are a number of options for consumers to obtain assistance and support in implementing their arrangements (e.g., independent advocacy, involvement of a network of consumer allies - described in Section E-1-k, below) PIHPs are the primary entity that supports consumers who direct their own services. Case managers, or another QIDP selected by the family, are responsible for providing support to consumers in these arrangements by working with them through the person-centered planning process to develop an IPOS and an individual budget, and to assure and implement staffing back-up plans as appropriate to the child's needs. The case manager or other QIDP is responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and service arrangements. Case managers (or other QIDPs) make sure that consumers receive the services as identified in the IPOS and that the arrangements are implemented smoothly.

Each PIHP is required to contract with fiscal intermediaries to provide financial management services. The fiscal intermediary performs a number of essential tasks to support consumer direction while assuring accountability for the public funds paid to these service providers. The fiscal intermediary has four basic areas of performance:

function as the employer agent for consumers directly employing workers to assure compliance with payroll tax and insurance requirements;

ensure compliance with requirements related to management of public funds, the direct employment of workers by consumers, and contracting for other authorized services;

facilitate successful implementation of the arrangements by monitoring the utilization of services and providing monthly invoices to the PIHP; and

offer supportive services to enable consumers to self-direct the services and supports they need as listed in application E-1 iii-Scope of FMS.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

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

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

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

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Although all consumers are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the consumer's representative. While consumers have the right to choose among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements, the following 2 waiver services are considered provider managed services only: 1. environmental accessibility adaptations/specialized medical equipment/supplies; and 2. financial management services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

(a) The PIHPs are responsible for providing information about participant direction opportunities. General information about arrangements that support the Choice Voucher System is made available to all waiver consumers and their families - initially and on-going - by providing them with a general brochure and with directions how to obtain more detailed information. When a parent of a child receiving waiver services expresses interest in participating in the Choice Voucher arrangements, the case manager (or other QIDP selected by the consumer's representative) will assist in gaining an understanding about the Choice Voucher System, and how those options might work for the consumer. As used throughout the application, "other QIDP selected by the family" refers to the fact a consumer can not be required to have a casemanager. The other QIDP would be a PIHP employee assigned to complete the functions identified under the Targeted Case Management (TCM) service in the MA Provider Manual.

Specific options and concerns such as the benefits of participant-direction, consumer responsibilities and potential liabilities are addressed through the person-centered planning process, which is mandated in the Mental Health Code. Each consumer develops an Individual Plan of Service (IPOS) through the person-centered planning (PCP) process, which involves his or her family and friends and a case manager (or other QIDP). The IPOS developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. The PCP Policy and Practice Guideline require that health and safety concerns be addressed. The MDHHS-CWP staff provide support and technical guidance to PIHPs with developing local capacity and with implementing options for participant direction.

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

(c) This information is provided throughout the consumers involvement with the PIHP. It starts from the time that the child and his/her parent approaches the PIHP for services and is provided with information regarding options for participant direction. Parents of minor children to be served by the CWP are to be provided with information about the Choice Voucher System. The PCP process is a critical time to address issues related to participant direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that concerns and needs are addressed. Choice Voucher arrangements begin when the PIHP and the consumer's representative reach an agreement on the IPOS, the services authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each consumer's representative who chooses to direct services and supports on behalf of the CWP-enrollee signs a Choice Voucher Agreement with the PIHP. This agreement is one of three required agreements needed to implement Choice Voucher arrangements, and clearly defines the duties and responsibilities of the parties (i.e., the fiscal intermediary, the consumer/parent as employer or contractor of the waiver provider, and the waiver service provider him/herself).

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Fiscal Intermediary	☐	☒
Enhanced Transportation	☒	☒
Community Living Supports	☒	☒
Overnight Health and Safety Support	☒	☒
Home Care Training, Non-Family	☐	☒
Respite	☒	☒
Specialty Service	☐	☒
Home Care Training, Family	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

Fiscal Intermediary Services

○ **FMS are provided as an administrative activity.**

Provide the following information

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

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

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

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

The contract between the PIHP and the FI stipulates the conditions of the agreement including the role and responsibility of the FI and how the FI is compensated for the financial management services it provides. The FI submits a claim to the PIHP for services rendered, and is reimbursed as agreed upon in the contract.

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

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

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

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

1. To receive, safeguard, manage and account for funds provided by the PIHP on behalf of each consumer and maintain complete and current financial records and supporting documentation verifying expenditures paid by the FI and a chart of accounts.

2. To assist consumers and their representatives to understand billing and documentation responsibilities.

3. To perform the financial administrative duties of employer and provide employer agent services to the consumer and his/her representative directly employing staff or contracting with clinical service providers. The FI must abide by all federal and state laws regarding payroll taxes and shall remain current with all payroll tax requirements. Both the PIHP and the consumer or consumer's representative must provide copies of all required employment documents including the Medicaid Provider Agreement to the FI.

4. To disburse funds to vendors and other providers of services and supports as directed by each consumer or consumer's representative for the services and supports selected by the consumer or consumer's representative and in accordance with the consumer's individual plan of services, only upon receipt of all required agreements including the Medicaid Provider Agreement and timesheets or invoices approved by the consumer or consumer's representative.

5. To maintain complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the FI on behalf of each consumer. These records must be retained for seven years from the start of FI services.

6. To record and maintain a monthly report of services and expenditures for each consumer to keep the PIHP and the consumer or consumer's representative informed of utilization and expenditures for services.

7. To safeguard all confidential information including the results of any background checks, and/or other documents pertaining to providers of services as needed or requested by the consumer or consumer's representative and/or the PIHP.

8. To flag for the PIHP and the consumer or consumer's representative deviations in provision of services authorized in accordance with the consumer's individual plan of services.

9. To reconcile all accrued expenses/accounts payable by the end of the fiscal year.

10. To make records regarding consumers available to the PIHP (on behalf of the State Medicaid Agency) as requested and to allow each consumer or consumer's representative access to his or her own records.

11. To commission a full financial audit of the FI's books and records as required by the PIHP and/or MDHHS.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

(a) MDHHS requires that PIHPs develop and implement a plan for assessing and monitoring FI performance that involves consumers, consumers' representatives and their allies in the assessment and monitoring. The plan should include a performance review process at least annually. Elements of the plan for assessing and monitoring FI performance must minimally include:

1. Fulfillment of FI Agreement requirements;

2. Competency in safeguarding, managing and disbursing funds;

3. Ability to indemnify the PIHP pursuant to FI agreement requirements;

4. Evaluation of consumer feedback and experience with and satisfaction of FI performance with alternate methods for collecting data from consumers;

5. Involvement of consumers and their allies in the development and implementation of the FI arrangement; and

6. Performing an audit of a sample of service utilization and expenditure reports.

(b) The PIHP is responsible for this monitoring. Compliance with the requirement is included in the Federal Compliance Section site review process.

(c) The FI performance review must be conducted at least annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the

payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

Specific options for participant direction are addressed through the person-centered planning process (PCP), which is mandated in the Michigan Mental Health Code. Each consumer develops an Individual Plan of Service (IPOS) through the PCP process, which involves his or her family and friends and a case manager or other qualified provider (such as an independent facilitator). For minor children and their families, this planning process includes a family-driven/youth-guided practice that builds upon the childs capacity to engage in activities to promote health, safety, habilitation, skill development, and participation in community life. The process honors the preferences, choices and abilities of the child and the family and involves the participation of the child, family and friends. This process results in a IPOS for the child that describes the services and supports that will be used to promote health and safety and achieve the identified preferences, choices, dreams and goals.

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

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

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Fiscal Intermediary	☒
Enhanced Transportation	☐
Community Living Supports	☐
Overnight Health and Safety Support	☐
Home Care Training, Non-Family	☐
Respite	☐
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	☐
Specialty Service	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Care Training, Family	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

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

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

A couple of options for independent advocacy are available. These are: utilizing a network of family and friends in the person-centered / family-driven / youth-guided planning process and using an Independent Facilitator to facilitate the planning process. In either case, the "independent advocate" is part of the person-centered planning process and assures that the consumer and his/her representative have an ally in directing the planning process. The independent advocate can assist by: arranging the planning meeting; helping the consumer to identify his/her dreams and goals; keeping the meeting focused on the consumer's wishes and needs; making sure the consumer is heard and understood; and providing information on a variety of supports, services and qualified providers. Independent advocates/ facilitators cannot provide other direct waiver services.

An Independent Facilitator should be someone trusted by the consumer or his/her representative. (For children, the Independent Facilitator cannot be the consumer's representative, as Independent Facilitators do not decide what will be paid for in the plan, authorize services and supports, or benefit from the outcome of the plan.) If the consumer or his/her representative would like assistance in finding an Independent Facilitator, they can ask their case manager, other service provider or an advocacy agency to provide a list of names and resumes of facilitators.

Participants can also retain an independent supports broker for assistance throughout the planning and implementing the individual plan of service and individual budget. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what will work best for him/her, are consistent with his/her needs and reflect the participant’s circumstances. The supports broker helps the participant explore the availability of community services and supports, access housing and employment, and makes the necessary arrangements to link the participant with those supports. Supports brokerage services offer practical skills training to enable participants to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving. When a participant uses an independent supports broker, the supports coordinator or supports coordinator assistant has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The consumer's representative has the freedom to modify or terminate the arrangements for Choice Voucher at any time. The most effective method for making changes is through the person-centered / family-driven / youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement. The decision of a consumer to terminate participant direction does not alter the need for services as identified in the IPOS. Upon termination of participant direction, the PIHP has an obligation for assuring that all identified service needs are met by providers on contract with or employed by the PIHP.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

A PIHP may terminate participant direction when the health and welfare of the consumer is in jeopardy due to the failure of the consumer's representative to direct services and supports or when the consumer's representative consistently fails to comply with contractual requirements.

The "The Choice Voucher System for the Children's Waiver Program" sets forth the procedure for the PIHP to follow. The Children's Waiver Voucher Agreement defines the responsibilities of the parties regarding participation in the Choice Voucher System and is in effect until it is changed or ended. Either party can initiate a change or end to the agreement by providing written notice to the other party. The PIHP must respond to any such notice from the responsible parent within seven (7) working days. Termination of the agreement does not alter the need for services as identified in the IPOS and does not affect the childs right to access services through the PIHP. Upon termination of participant direction, the CMHSP has an obligation for assuring that all identified service needs are met by providers on contract with or employed by the PIHP.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		135
Year 2		159
Year 3		174
Year 4		198
Year 5		219

Appendix E: Participant Direction of Services

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

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

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

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

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

In the Agency with Choice model, participants serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (described in this document as “AWC provider”) serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing worker’s compensation insurance). In the Agency with Choice model, participants may get help with selecting their workers (for example, the AWC provider may have a pool of workers available for consideration by participants). The AWC provider may also provide back-up workers when the participant’s regular worker is not available. Like traditional staffing agencies, the AWC provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that participants directly employing workers cannot provide. The Agency with Choice model is also an important option for participants who do not want to directly employ workers or who want to transition into direct employment.

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

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

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

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☒ **Other**

Specify:

The fiscal intermediary is responsible for conducting criminal background checks for directly employed providers. The cost is built into their monthly fee. Refer professional staff to FI for personal services contract. Terminate personal services contract with unsatisfactory professional staff.

Appendix E: Participant Direction of Services

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

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

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

☒ **Reallocate funds among services included in the budget**

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

☒ **Substitute service providers**

☒ **Schedule the provision of services**

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

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

1. Identify clinical service providers and refer to the FI.
2. Execute and terminate purchase of service agreements with clinical service providers.
3. Authorize payment for contracted clinical service providers.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

An individual budget includes the expected or estimated costs of a concrete approach of obtaining the mental health services and supports included in the IPOS. Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP). Both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the participant. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the participant is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process.

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

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

This process involves costing out the services and supports using the rates for providers chosen by the participant and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Worker's Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS. The individual budget must include the fiscal intermediary fee if a fiscal intermediary is utilized.

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a participant chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a fiscal intermediary be used.

Fiscal intermediary is a waiver service and is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the fiscal intermediary to provide financial management services (FMS) and sets the rate and costs for the services. The average monthly fee has ranged from $75.00 to $125.00. Actual costs for the FMS will vary depending on the individual's needs and usage of FMS, as well as the negotiated rate between the PIHP and fiscal intermediary.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the IPOS, using the PCP process, or is determined as applied to a pre-existing, sufficient IPOS, using the PCP process. Budget authorization is contingent upon the participant and the PIHP entity reaching agreement on the amount of the budget and on the methods that will, or may, be applied by the participant to implement the plan and the individual budget. The budget will be provided to the participant in written form, as an attachment to the Self-Determination Agreement that outlines the expectations and obligations of the participant and the PIHP. The participant's plan is also attached to the agreement.

The participant's targeted case manager or QIDP (or other qualified provider selected by the participant) are expected to provide assistance to the participant in understanding the budget and how to utilize it. In situations where the participant also has an independent supports broker, the broker will assist the participant to understand and apply the budget. The participant may seek an adjustment to the individual budget by requesting this from their targeted case manager or other chosen qualified provider. The targeted case manager or QIDP (or other qualified provider selected by the participant) will be expected to assist the participant to convene a meeting including the participant's chosen family members and allies, and to assure facilitation of a PCP process to review and reconsider the budget. A change in the budget is not effective unless the participant and the PIHP have agreed to the changes.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. Most participants use FMS through a fiscal intermediary even if they only contract with providers already under contract with the PIHP; however, there is no requirement that they do so.

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

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

If using FMS through a fiscal intermediary, the targeted case manager or QIDP (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact they have with the participant, the targeted case manager or QIDP (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report. If the participant does not use a fiscal intermediary because he or she only contracts with providers already under contract with the PIHP, the PIHP must provide a monthly budget report to the participant and targeted case manager or QIDP (or other qualified provider) so the participant can effectively manage his or her budget and thereby, exercise budget authority.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

When an individual presents for intake at a Prepaid Inpatient Health Plan (PIHP) he or she is provided basic information regarding available services, recipient rights, local dispute resolution and administrative hearings. At the time of Individual Plan of Service (IPOS) development, the consumer is again notified of these rights.

The MDHHS Administrative Tribunal housed within the State Office of Administrative Hearings and Rules (SOAHR) provides a hearing to appellants who do not agree with a decision made by the Michigan Department of Health and Human Services (MDHHS) or PIHP. The Administrative Tribunal issues timely and legally accurate hearing decisions and orders. Consumers can access the Administrative Tribunal Policy and Procedures manual on the MDHHS website.

The parent or guardian must be sent a written notice of actions affecting eligibility or amounts of Medicaid benefits or Medicaid covered services for their child. This notice must be provided by the PIHP to the parent/guardian for any of the following: choice of CWP services vs. institutional services; choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements; and denial, reduction, suspension, reduction or termination of a waiver service. The parent/guardian or authorized hearing representative has 90 calendar days from the date of the written notice of action to request a hearing. The SOAHR must receive the written hearing request within that 90-day period.

There are two types of written notice: 1) Adequate Action Notice, which is a written notice sent to the parent or guardian at the same time an action takes effect. Adequate notice is provided in the following circumstances: Denial of new services not currently being provided; Approval or denial of an application; Completion of an IPOS; Increase in service benefits. 2) Advance Action Notice is required when an action is being taken to reduce, suspend or terminate a benefit or service the child is currently receiving. The notice must be mailed at least 12 days before the intended action takes effect. The notice of action includes instructions for requesting expedited resolution if the family so wishes and the right to retain representation at the hearing. If the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the Administrative Law Judge (ALJ) or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing. A number of resources are available to assist families who wish help in requesting a Fair Hearing. These include, but are not limited to, the case manager, PIHP customer services representative, recipient rights officer, SOAHR office, CWP staff, and Protection and Advocacy.

The Request for Hearing form (DCH-0092) or its equivalent is sent to the parent or guardian with all adequate or advance notices. Notices of adverse actions and the opportunity to request a Fair Hearing are kept in the child's record at the PIHP. It is the responsibility of the PIHP to designate a hearings coordinator who will serve as the liaison between the agency and the Administrative Tribunal. The purpose of the hearings coordinator is to serve as the single contact point for the Administrative Tribunal in order to communicate procedural aspects of any case. The hearings coordinator may also represent the PIHP at a hearing.

An appellant or AHR may agree to withdraw their Request for Hearing at any time during the hearing process. The appellant or AHR should complete the DCH-0093 – Request for Withdrawal of Appeal or its equivalent and return it immediately in the postage paid envelope to the State Office of Administrative Hearings and Rules. The Request for Withdrawal of Appeal can be ordered via the Administrative Tribunal Forms Requisition. When an issue is still in dispute, the appellant or AHR is not to be asked to withdraw their Request for Hearing or to be mailed a withdrawal form unless asked to do so by the appellant.

When all issues have been resolved, the appellant or AHR may wish to withdraw the Request for Hearing. A Request for Withdrawal of Appeal form can be submitted, or the appellant or AHR can submit a signed, written statement. The withdrawal must clearly state why the appellant or AHR has decided to withdraw the Request for Hearing. All identifying case information is entered on the withdrawal form, and the original copy is attached to the request and forwarded to the SOAHR. A copy of the withdrawal is maintained in the child’s record.

All documentation is maintained in the waiver consumer's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a) The State has established a grievance and appeals system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 10 IHPs. The Grievance and Appeal Technical Requirement is Attachment 6.3.1.1 of the MDHHS/PIHP Contract.

b) Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, such as a denial, termination, or reduction of a service, and those challenging anything else, such as a beneficiary's dissatisfaction with service, e.g., quality of care or services provided or aspects of interpersonal relationships between a service provider and the beneficiary. A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

Beneficiary Appeals: Local appeals, like requests for fair hearings, are initiated by notice of an adverse action. The beneficiary or his/her legal representative may request a local appeal concurrently with filing a request for a fair hearing and under the following conditions:
- The beneficiary or his/her legal representative has 45 days from the date of the notice of action to request a local appeal;
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary or his/her legal representative requests expedited resolution;
- The beneficiary or his/her legal representative may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals, e.g. Customer Services, Office of Recipient Rights;
- If the beneficiary or his/her legal representative requests a local appeal not more than 12 days from the date of the notice of action, the PIHP must reinstate or continue the service(s) until disposition of the fair hearing.

When a beneficiary or his/her legal representative requests a local appeal, the PIHP is required to:
- Give the beneficiary or his/her legal representative reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability;
- Acknowledge receipt of each appeal;
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program;
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making;
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal relates to a denial based on lack of medical necessity or involves other clinical issues;
-Provide the beneficiary, or representative with reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing; the opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process; the opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate; information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition of Appeal requirements:
- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include the right to request a state fair hearing, and how to do so; the right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition of Appeal must be provided within the following timeframes:
Standard Resolution: The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed 45 days from the day the PIHP receives the appeal.

Expedited Resolution: The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than three (3) working days after the PIHP receives the request for expedited resolution of the appeal. An

expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

The PIHP may extend the notice of disposition timeframe by up to 14 calendar days if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the beneficiary's interest.

If the PIHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal make reasonable efforts to give the beneficiary prompt oral notice of the denial, and give the beneficiary follow up written notice within two (2) calendar days.

Beneficiary grievances: Medicaid beneficiaries have the right to a local grievance process for issues that are not "actions". The grievance is filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance. A grievance may be filed at any time by the beneficiary, guardian, or parent of a minor child
or his/her legal representative. For a grievance, the beneficiary would not have access to the state fair hearing process unless the PIHP fails to respond to the grievance within 60 calendar days. This constitutes an 'action", and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:
- give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- acknowledge receipt of the grievance;
- log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program;
- ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making;
- ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance involves clinical issues or involves the denial of an expedited resolution of an appeal (of an action);
- submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination;
- provide the beneficiary a written notice of disposition not to exceed 60 calendar days from the day PIHP received the grievance/complaint. The content of the notice of disposition must include the results of the grievance process, date the grievance process was concluded, the beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and how to access the fair hearing process.

c) The PIHP must provide notice of the right to request a fair hearing to a beneficiary any time there is an adverse action as described in Appendix F-1. As stated previously, the beneficiary may request a Medicaid Fair Hearing concurrently with a request to have the adverse action addressed through the local dispute resolution process. The beneficiary also has the right to request a state fair hearing before exhausting the PIHP level appeal of an "action". The requirements are specified in the MDHHS/PIHP contract in Attachment 6.3.1.1

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents may be received and investigated by the PIHP ORR and/or the PIHP, as well as by law enforcement or other state agencies as applicable depending on the nature of the incident.
IMMEDIATE EVENT REPORTING: Per section 6.1.1 of the MDHHS-BHDDA/PIHP contract, the PIHP must immediately report certain events to MDHHS through the PIHP (as described in Section G-1-b and as required by Section P 6.7.1.1 of the MDHHS/PIHP Contract). For deaths, the PIHP must submit to MDHHS within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of discharge from a state-operated service or a death that occurs as a result of suspected staff member action or inaction. The written report will include 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/PIHP'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 MDHHS internal process.

SENTINEL EVENT: The PIHP 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 ERS through the PIHP to MDHHS. In the MDHHS-BHDDA/PIHP contract, Attachment C 6.8.1.1 requires that each PIHP must have a Quality Improvement Program (QIP). The QIP describes, and the PIHP implements, the process of the review and follow-up of sentinel events. Reporting is required for any sentinel event for children enrolled in the CWP The PIHP 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 CWP 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 managed and reported through the PIHP according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined in the MDHHS/PIHP 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 MDHHS requires PIHPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the PIHP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. [excerpt from MDHHA-MHSA Guidance on Sentinel Event Reporting]. Sentinel event reporting is submitted in aggregate to MDHHS on a quarterly basis. MDHHS will continue to evaluate the process for sentinel event reporting during Federal Compliance site reviews.

EVENT REPORTING SYSTEM: The new ERS requires the PIHP to report the following events through the PIHP to MDHHS-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 ERS would also be

investigated by the PIHP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. Additionally, some of the incidents reported in the ERS, such as a death or injury, could result in a criminal investigation or referral to Child Protective Services (CPS). All events are included in aggregate trend and analysis reports. Event 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 MDHHS internal process. The CWP is submitting an action plan with this renewal regarding the MDHHS internal process.

Timeframes for reporting the five specified events in the ERS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the cause of death was determined. For the purpose of the ERS, a consumer's death shall be reported as a suicide when either one of the following two conditions exists, the PIHP serving the consumer determines, through its death review process, that the consumer's death was a suicide, or the official death report (i.e., coroner's report) indicates that the consumer's death was a suicide. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

Non-suicide death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the PIHP attempts to determine whether the death was due to suicide. In this case the submission is due within 30 days of the end of the month in which the PIHP determined the death was not due to suicide.

Emergency medical treatment due to injury or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization due to injury or medication error: Due within 60 days after the end of the month in which the hospitalization began.

Arrest: Due within 60 days after the end of the month in which the arrest occurred.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the PIHP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the PIHP 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 PIHP 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 PIHPs. Aggregate data are shared with MDHHS Mental Health and Substance Abuse Management team, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

OTHER: In the event of a reported incident of a child, MDHHS-CPS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring consumer safety. The PIHP ORR is responsible for investigating rights violations. The MDHHS Department of Licensing and Regulatory Affairs (LARA) 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.

If, during a Federal Compliance on-site visit, 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,

which must be completed in five to seven business days.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDHHS entitled YOUR RIGHTS When Receiving Mental Health Services in Michigan at the time of admission into services and periodically thereafter. The CWP consumer's case manager or other QIDP provides information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of CWP services and subsequently as often as needed by the consumer or the parent/guardian, but at least annually during a person-centered planning meeting. This is in accordance with Section 330.1706 of the Mental Health Code: applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available or review by applicants and recipients." From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the Mental Health Code mandated protections from abuse, neglect, and exploitation, and how consumers (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the consumer may have experienced abuse, neglect or exploitation. In an effort to make it easier for members of the general public, including family members, to report suspected abuse, neglect, or exploitation, the state ORR has modified its web page on how and where to report.

Chapter 7 of the Michigan Mental Health Code also requires that every CMHSP ORR must assure that all program sites, whether directly operated or through contract with the PIHP, have rights booklets available in public areas for recipients, guardians, care-givers, etc. The booklet describes the various rights afforded the individual under the U.S. Constitution, Michigan Constitution, the Michigan Mental Health Code and MDHHS Administrative Rules as well as contact information for the PIHP ORR if the recipient, legal representative, or anyone on behalf of the recipient feels that the recipients rights have been violated, including the right to be free from abuse or neglect.

Section 6.3.1 of the MDHHS-BHDDA/PIHP contract requires that each PIHP must provide customer services and there is an assigned customer services coordinator for each PIHP that oversees customer services at the PIHP. In addition, each PIHP is either a stand-alone PIHP or is in an affiliation of PIHPs where Attachment P.6.3.1.1 of the MDHHS-BHDDA/PIHP contract also applies. A customer services handbook which has been approved by MDHHS is provided to individuals at the time services are initiated and offered again at least annually. Individuals are provided information regarding mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a consumer. The Customer Services Unit may also, upon request of the consumer or family, assist with contacting the local Office of Recipient Rights for assistance with an issue related to abuse, neglect or exploitation.

The ORR also houses a Training Unit to ensure that recipient rights initiatives are consistently implemented statewide. In addition to training staff of PIHPS and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients rights. PIHP ORRs conduct rights informational sessions for consumers, family members, advocates and interested others. Additionally, the MDHHS holds annual Recipient Rights, Consumer, and Home and Community Based Waiver Conferences, all of which include consumers and/or their families. These conferences provided Recipient Rights training that describe consumer rights and the complaint resolution and appeal process.

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

Critical incidents may be 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.

IMMEDIATE EVENT REPORTING: Per section 6.1.1 of the MDHHS-BHDDA/PIHP contract, the PIHP must immediately report certain events to MDHHS through the PIHP (as described in Section G-1-b and as required by Section P 6.7.1.1 of the MDHHS/PIHP Contract). For deaths, the PIHP must submit to MDHHS within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of discharge from a state-operated service or a death that occurs as a result of suspected staff member action or inaction. The written report will include 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 coroners 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 plan for monitoring to assure any quality improvement actions are implemented. Immediate event reporting is considered an egregious situation and is reviewed through the MDHHS internal process.

SENTINEL EVENT: The PIHP 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 ERS through the PIHP to MDHHS. In the MDHHS-BHDDA/PIHP contract, Attachment C 6.8.1.1 requires that each PIHP must have a Quality Improvement Program (QIP). The QIP describes, and the PIHP implements, the process of the review and follow-up of sentinel events. Reporting is required for any sentinel event for children enrolled in the CWP. The PIHP 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 CWP 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., coroners 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 managed and reported through the PIHP according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined in the MDHHS/PIHP 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. 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.

EVENT REPORTING SYSTEM: The new ERS requires the PIHP to report the following events through the PIHP to MDHHS-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 ERS would also be investigated by the PIHP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. Additionally, some of the incidents reported in the ERS, such as a death or injury, could result in a criminal investigation or referral to Child Protective Services (CPS). All events are included in aggregate trend and analysis reports. Event 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 MDHHS internal process. The CWP is submitting an action plan with this renewal regarding the MDHHS internal process.

Timeframes for reporting the five specified events in the ERS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the cause of death was determined. For the purpose of the ERS, a consumers death shall be reported as a suicide when either one of the following two conditions exists, the PIHP serving the consumer determines, through its death review process, that the consumers death was a suicide, or the official death report (i.e., coroners report) indicates that the consumers death was a suicide. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a best judgment determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this best judgment determination occurred.

Non-suicide death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the PIHP attempts to determine whether the death was due to suicide. In this case the submission is due within 30 days of the end of the month in which the PIHP determined the death was not due to suicide.

Emergency medical treatment due to injury or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization due to injury or medication error: Due within 60 days after the end of the month in which the hospitalization began.

Arrest: Due within 60 days after the end of the month in which the arrest occurred.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the PIHP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the PIHP 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 PIHP 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 PIHPs. Aggregate data are shared with MDHHS Mental Health and Substance Abuse Management team, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

OTHER: In the event of a reported incident of a child, MDHHS-CPS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring consumer safety. The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigating licensing rule violations. Law enforcement may also be conducting an investigation related to possible criminal activity.

If, during a Federal Compliance on-site visit, 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, which must be completed in five to seven business days.

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

EVENT REPORTING SYSTEM: The ERS will allow MDHHS to better monitor the types of events which occur in particular populations, such as the ability to monitor incidents for CWP consumers. Since individual consumer identification will be included with each event, MDHHS can look for potential trends by comparing reportable events to data already existing in the Quality Improvement/Encounter files. MDHHS will oversee the PIHP responsibility for critical incident management for the CWP waiver population by measuring the rate of critical incidents for CWP consumers. After establishing a baseline "occurrence" rate (addressed in action plan), MDHHS 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.

MDHHS staff reviews the events reported and identifies priority events that warrant additional review through the MDHHS internal process. As a result of the review, MDHHS may contact the PIHP when concerns arise regarding CWP consumers. Technical assistance, consultation, and referrals for additional follow-up or training are provided as required. On-site follow-up on reported events takes place at a maximum during MDHHS biennial site reviews. More frequent reviews by MDHHS staff may be required in addition to site reviews, depending on the situation. During site reviews, MDHHS staff examine the event reporting process, their process for conducting root cause analysis on sentinel events, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of reportable event would re-occur. Any noted shortcomings in the processes or outcomes would be reflected in the PIHPs 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 MDHHS. 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 MDHHS would be repeated until a satisfactory plan is achieved. MDHHS conducts an on-site review to assess the efficacy of the plan of correction approximately one year after the full review was conducted. This state oversight by the Federal Compliance Section assures the necessary processes are in place for participant safeguards.

As part of Michigans overall quality oversight of public mental health services, including the CWP, the External Quality Reviews examine the performance indicator for sentinel event reporting to assure that the QAPIP at each PIHP (and affiliate PIHPs 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. In the most recent report for 2009, 100% of PIHPs/CMHSPs had the required processes in place to review and follow-up on sentinel events. This report indicates that the processes are in place for all recipients of mental health services, including CWP consumers. MDHHS 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 PIHP ORRs report to MDHHS the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations, 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 MDHHS include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local ORR, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The PIHP level data is aggregated to the PIHP level where affiliations exist. It should be noted that starting in fiscal year 2010, each PIHP rights office must include in its semiannual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population, including CWP 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:

MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742)
The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700 [j]).

In addition, the use of restrictive interventions is addressed in the MDHHS 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 MDHHS-BHDDA and the PIHPs; and the Agreement Between MDHHS-BHDDA and PIHPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.

Monitoring to assure that PIHPs/PIHPs are not using restraints or seclusion is done by the MDHHS-BHDDAA 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. Each PIHP 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 MDHHS, PIHPs and licensed psychiatric facilities. All are internal, and are subordinate only to the Department, PIHP or licensed hospital director. If there is a rights complaint against the PIHP Director, the investigation must be conducted by another PIHP rights office or the MDHHS 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 PIHP. The local Appeals committee is comprised of at least 3 members of the Recipient Rights Advisory Committee, 2 PIHP Board members and 2 primary consumers. None may be employed by MDHHS or the PIHP. Included in the potential decisions by the Committee, a case may be sent to the MDHHS Office of Recipient Rights for external investigation. The second level of appeal is to the Michigan Department of Energy, Labor and Economic Growth Office of Administrative Hearings and Appeals where an administrative law judge reviews the conclusion of the local Appeals Committee and either upholds or sends the case back to the PIHP rights office for re-investigation.

LARA 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 LARA during announced or unannounced inspections and at the time of the biennial licensure process. If the PIHP rights office receives a complaint involving a consumer residing in a licensed foster care home, the rights office will notify LARA, Adult Protective Services or Children's Protective Services as applicable and as required by law. LARA and APS/CPS will notify the PIHP rights offices as well when each receives a complaint involving a consumer of PIHP services. In most cases the investigation will be coordinated between the 3 entities. In addition, if LARA were to identify an egregious situation, such as unlawful use of restraint or seclusion, the director of LARA (or designee) may contact the director of the Federal Compliance Section (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 LARA to discuss issues of concern for mental health consumers served in licensed settings.

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

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established

concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

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

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

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

The Michigan Mental Health Code 330.1726 requires (in part):
- A recipient is entitled to unimpeded, private and uncensored communication with others by mail and telephone and to visit with persons of his or her choice;
- The right of a recipient to communicate by mail or telephone or receive visitors shall not be further limited except as authorized in the person's individual plan of services.

The Michigan Mental Health Code 330.1744 requires (in part):
- The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.

MDHHS Administrative Rules 330.7199 requires (in part):
-The plan [of services and supports] shall identify, at a minimum, all of the following:
Any restrictions or limitations of the recipient's rights. Such restrictions, limitations or intrusive behavior treatment techniques shall be reviewed and approved by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. Any restriction or limitation shall be justified, time-limited and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

Use of restrictive interventions is addressed in the MDHHS 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 MDHHS-BHDDA and the PIHPs; and the Agreement Between MDHHS-BHDDA and PIHPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1. The PIHPs must use a specially constituted committee, often referred to as a "behavior treatment plan review committee" or "Committee". Typically each PIHP has a Committee; however, a PIHP comprised of an affiliation of PIHPs 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.

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. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited.

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 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); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

As part of its review, the Committee would determine whether causal analysis of the behavior has been performed and whether positive behavioral supports and interventions have been adequately pursued prior to utilizing intrusive or restrictive techniques. Plans with intrusive or restrictive techniques require a quarterly review minimally. The Committee also ensures that the behavior treatment plan addresses the monitoring and staff training to assure consistent implementation and documentation of the interventions. As part of the PIHP's QAPIP or the PIHP's QIP, the Committee's effectiveness should have stakeholder input, including individuals who had approved plans, as well as family members and advocates.

The use of physical management would be reported on an incident report that is reviewed by the PIHP ORR. If after investigation by the PIHP 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 PIHP, (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 PIHP 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:

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

In addition to monitoring critical incident reporting, MDHHS-BHDDA oversees the activities of the PIHP (or PIHP as applicable) Behavior Treatment Plan Review Committees through quarterly reporting from Committees to MDHHS for CWP consumers whose plans include the use of intrusive or restrictive techniques, biennial Site Reviews and more frequent oversight if issues or critical incidents related to the use of restrictive interventions are noted. If critical incidents are reported related to the use of restrictive interventions, MDHHS-BHDDA may require the PIHP and PIHP staff to receive training in the culture of gentleness and positive behavioral supports, as well as recommend other approaches or strategies as appropriate. The data on the use of intrusive and restrictive techniques from CMHSP Behavior Treatment Plan Review Committees must be available for MDHHS review.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Improvement Program, and be available for MDHHS review as required in the PIHP 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:

MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Program contract between MDHHS-BHDDA and the PIHPs; the Agreement Between MDHHS-BHDDA and PIHPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d.

Each rights office established by the Mental Health Code, including those of the PIHPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per MDHHS Administrative Rule 400.14308 as follows:

R 400.14308 Resident behavior interventions prohibitions.

(2)A licensee, direct care staff, the administrator, members of the household,
volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(a)Use any form of punishment.
(b)Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
(c)Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
(d)Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS-BHDDA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

Most CWP consumers live with family and medication management and administration are the family's responsibility. In those few instances where the consumer and family use licensed settings, the PIHPs have ongoing responsibility for "second line" management and monitoring of consumer medication regimens. "First line" management and monitoring are the responsibility of the prescribing medical professional. The consumer's IPOS must contain complete information about their medication 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 consumer's planning 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. Monitoring of consumer's needs by the case manager or other QIDP includes general monitoring of the effectiveness of the consumer's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with the consumer, and discussion with direct care and other staff as appropriate. Typically, case managers or other QIDPs meet at least once per month face-to-face with CWP consumers and their families.

The PIHP 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 PIHP medical professionals specified in the plan, case managers or other QIDPs 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.

Michigan's DHHS licenses and certifies child and family foster care settings in which respite services are provided for CWP consumers. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. MDHHS 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 MDHHS-BHDDA and PIHPs 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 PIHPs and specify committee membership and review requirements are included in G-2-b. Committee reviews of the use of behavior modifying medications must be completed at least quarterly, but may be completed more frequently at the discretion of the committee. Reports from the Committee must be submitted to MDHHS for CWP consumers on a quarterly basis.

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

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

The State currently requires PIHPs to report on medication errors that rise to the level of a sentinel event. This information is reported to MDHHS-BHDDA on a quarterly basis through the current sentinel event reporting, which will overlap through FY11 with the new critical incident reporting system effective 10/1/10. This system will capture individually identifiable medication errors that required medical follow-up or hospitalization.

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 Children's Waiver Program services to which this appendix applies are: respite provided in a foster home, licensed respite homes, and licensed camps. These settings are licensed under PA 116, as amended and the rules applicable thereto. While in any of these settings, the waiver service provider would administer medications as prescribed by the physician.

The following rule applies to licensed family foster homes and respite 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.

Michigan’s DHHS licenses and certifies child and family foster care settings in which respite services are provided for CWP consumers. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. MDHHS 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.

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:

The Children's Waiver Program services to which this appendix applies are: respite provided in a foster home, licensed respite homes, and licensed camps. These settings are licensed under PA 116, as amended and the rules applicable thereto. While in any of these settings, the waiver service provider would administer medications as prescribed by the physician.

The following rule applies to licensed family foster homes and respite 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.

Michigan’s DHHS licenses and certifies child and family foster care settings in which respite services are provided for CWP consumers. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. MDHHS 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.

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

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

On-site follow-up on reported sentinel events regarding medication errors takes place at a maximum during Federal Compliance Section biennial site reviews. During these site reviews, MDHHS-BHDDA staff reviews the PIHP sentinel event reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that this type of sentinel event would re-occur. Any noted shortcomings in the processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP (including PIHP affiliates as applicable). Post-sentinel event data submission, MDHHS-BHDDA staff contacts the PIHPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required

(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:

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

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

On-site follow-up on reported critical incidents regarding medication errors takes place at a maximum during QMP biennial site reviews. During these site reviews, MDHHS-BHDDA staff reviews the PIHP critical incidents reporting process, their process for conducting root cause analysis, as well as the success of actions taken to prevent or reduce the likelihood that this type of sentinel event would re-occur. Any noted shortcomings in the processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP (includingPIHP affiliates as applicable). Post-sentinel event data submission, MDHHS-BHDDA staff contacts the PIHPs to confirm the accuracy of submitted data when data submission indicates a sentinel event has taken place. Technical assistance, consultation, and referrals for additional follow-up are provided as required.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of critical incidents reported for CWP enrollees. Numerator: Number of critical incidents reported for CWP enrollees. Denominator: All CWP enrollees.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrollees requiring hospitalization d/t injury related to use of a restrictive intervention. N: Number of enrollees requiring hospitalization d/t 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):*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of substantiated abuse and neglect events reported for waiver participants. Numerator: Number of substantiated abuse and neglect events reported for waiver participants. Denominator: All CWP enrollees.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

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

Performance Measures

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

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

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

MDHHS will analyze a 100% sample of all reported critical incidents involving CWP consumers from the ERS, as well as analyze subcategories of critical incidents reported through the ERS who required hospitalization due to an injury related to use of restrictive intervention or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDHHS is particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effective of preventive strategies.

The PIHPs submit, on a quarterly basis, aggregate data by event category for number of sentinel events and plans of action or interventions which occurred during the three month period. The MDHHS-BHDDA analyzes the data and prepares a report on the number of sentinel events (by category) per thousand persons served who meet the population definition. As with all performance indicators, MDHHS
reviews performance, with potential follow-up by contract managers to determine what quality improvement action is taking place; and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.

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

In the IPG Final Report, CMS requested information regarding effectiveness of the prevention policies and procedures for this waiver. 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’s case manager or other QIDP and the child’s Team.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 PIHP ORR or PIHP, the system described in this Appendix would require the following steps be taken. Any critical incident for a participant has a short-term response to assure the immediate health and welfare of the participant for whom the incident was reported and a longer- term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified. Second, the PIHP 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 PIHP ORR, that office begins the process of determining whether there may have been a violation of the participant's rights. If the PIHP 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 PIHP must develop and implement either a) a plan of action or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The PIHP ORR also follows its process to investigate and recommend remedial action to the PIHP Director for follow-up.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the §1915(b) Managed Specialty Supports and Services waiver Control #MI-14.R05, Childrens Waiver Program (CWP) Control #4119.90.R3.01, Habilitation Support Waiver (HSW) Control #0167.90.R04, and the Waiver for Children with Serious Emotional Disturbance (SEDW) Control #0438.R01.02. The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of fund source. Michigans Quality Improvement Strategy includes activities by the Prepaid Inpatient Health Plans and the Community Mental Health Programs through contract requirements for Quality Assessment and Performance Improvement Programs (QAPIP). Eight of the Prepaid Inpatient Health Plans (PIHPs) are stand-alone Community Mental Health Services Programs (CMHSPs) and the remaining CMHSPs are affiliated as PIHPs. The Quality Improvement requirements and strategies are very similar in both the PIHP and CMHSP contracts in order to tie all quality improvement activities into the states overall Quality Management Plan. The contract between MDHHS and the PIHPs requires the PIHP to have a fully operational QAPIP (also referred to in the PIHP contract as the Quality Improvement Plan or QIP) in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement, attachment C6.8.1.1. The QIP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis. The contract between MDHHS and PIHPs also includes reporting requirements by the PIHPs related to quality improvement and encounter reporting data. Data can be analyzed at the individual CWP consumer level, the CWP program level, or aggregated with other state-level data for use in trending, prioritizing, and implementing systems improvements.
The QMP site review team issues a report of findings to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDHHS in 30 days. If the PIHP is comprised of affiliate CMHSPs, the QMP issues separate reports to the CMHSPs regarding CWP findings. On-site follow-up will be conducted the following year or sooner if non-compliance with standards is an issue. Results of the MDHHS on-site reviews are shared with MDHHS-BHDDA, the Quality Improvement Council (QIC), and CWP staff. Information is used by MDHHS to assure individual-level remediation is completed by the PIHP, as well as to take contract action as needed. Information related to individual-level remediation is also aggregated and analyzed to identify trends at specific PIHPs or throughout the state that may be used for system improvements. The QIC also uses information to make recommendations for system improvements to the MDHHS management team. This would include the review of issues related to the PIHP QIP, as well as the PIHP QAPIP.

Michigans quality management strategy has been developed with the input of consumers, the Mental Health QIC (comprised of consumers and advocates), and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Service Boards. Michigans quality management strategy also reflects feedback from other stakeholders or processes, the Encounter Data Integrity Team (EDIT), the EQR, and the terms and conditions from CMS previous waiver approvals. Input from stakeholders is used in prioritizing and improving the quality improvement strategy.
MDHHS uses its Fair Hearings database to track the trends of the types of requests for fair hearing and their resolution, to identify PIHPs that have particularly high volumes of appeals and to identify themes, such as appeals related to a specific service. Trends that are noted may be addressed through training, policy clarification, or other methods. MDHHS also has periodic meetings with the Administrative Tribunal to address trends and identify solutions.

Other examples of design changes resulting from the QI process include workshops for the Annual Statewide Waiver conference, identifying topics for technical assistance workshops at state and local levels, and providing training to CWP consumers and their families.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☐ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: The QI Committee meets bi-monthly. For the PIHPs and MDHHS, 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.

MDHHS-BHDDA uses performance indicators to measure the performance of the PIHP/CMHSP on a number of domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management. Data collected for performance indicators can be identified at the individual CWP participant level if necessary.

Indicators are used to alert MDHHS-BHDDA of systemic issues and PIHP/CMHSP-specific issues that need to be addressed immediately; to identify trends to watch; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter data located in MDHHS's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDHHS and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action. Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDHHS web site. Results of the performance indicators are shared with MDHHS-BHDDA management team, the QIC and CWP staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Participant level demographic data are reported monthly for each individual. A significant amount of work was done between MDHHS-BHDDA Federal Compliance Section and the PIHPs to identify the process and challenges with demographic data used by the CWP for payment calculations. Aggregate data from the encounter data system are shared with the MDHHS-BHDDA management team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

PIHPs are required by contract to submit Medicaid Utilization and Net Cost (MUNC) reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP and can be analyzed at the CWP participant level. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDHHS to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDHHS-BHDDA management team, the EDIT, and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Critical Incidents are reported, reviewed, investigated and acted upon at the local level by each PIHP for all CWP participants, as well as the following groups: beneficiaries receiving Targeted Case Management, participants enrolled in the CWP and the SEDW, and those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDHHS semi-annually. Aggregate data are shared with MDHHS-BHDDA management team, the QIC and staff from the Federal Compliance Section. Information is used by MDHHS to take contract action as needed, becomes the focus of on-site reviews conducted by MDHHS, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP Offices of Recipient Rights (ORR) report summaries of all allegations received and investigated, identify intervention taken, and the number of allegations substantiated. The summaries are reported by category of rights violations. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature. Data collection improvements distinguish Medicaid consumers from other individuals served. Information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDHHS-MHSA BHDDA management team, the QIC, and staff from Federal Compliance Section . Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

The EQR process checks for PIHP policy and processes and evidence that those policies and processes are being implemented. Although the data is not necessarily specific to the CWP, because CWP participants represent a significant percentage of the Medicaid beneficiaries who have intellectual/developmental disabilities, the findings of PIHP performance are considered a valid data source for assuring the PIHP policies and procedures in the 13 areas are met. This data source is also used to identify areas for system design change and improvements.

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

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDHHS performance improvement project reports are shared with MDHHS-BHDDA management team, the QIC and CWP staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDHHS-BHDDA staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the QMP on-site reviews and the EQRs are shared with MDHHS-BHDDA management team and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

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. One example of an outcome of this periodic evaluation of Michigan's QI strategy is the QI Councils recommendations to integrate the CWP on-site review process with that of the QMP site review process, which was implemented effective 10/1/2010. The QIS is reviewed on an on-going basis by MDHHS-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 MDHHS-BHDDA/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 MDHHS-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 MDHHS-MHSA 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 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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Children's Waiver operates concurrently with the State's §1115 Pathway to Integration waiver. The CWP capitation payments are made to the PIHPs for the delivery of waiver services and PIHPs in turn, pays within [and when requested, outside] their networks of contracted providers. There are no fee-for-service payments for waiver services.

a) The MDHHS/PIHP contract includes requirements for PIHPs to complete independent audits.

b) Pursuant to the MDHHS/PIHP and MDHHS/CMHSP contracts, PIHPs and CMHSPs must submit to MDHHS a Financial Statement Audit and a Compliance Examination Report conducted in accordance with the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements 10 and the CMH Compliance Examination Guidelines attached to the MDHHS/PIHP and MDHHS/CMHSP contracts.

The annual independent financial audit must clearly indicate the operating results for the reporting period and financial position of the PIHP at the end of the fiscal year. The Financial Statement Audit must be conducted in accordance with Generally Accepted Auditing Standards.

The annual CMHSP Compliance Examination requires that an independent auditor examine compliance issues related to contracts between PIHPs and the MDHHS to manage the concurrent §1115 and the 1915(c) waiver programs as well as general fund and Mental Health Block Grant funds. PIHPs must assure that compliance issues are monitored by either requiring their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs, or require the affiliated CMHSPs to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. The CMH Compliance Examination does not replace or remove any other audit requirements that may exist, such as a financial statement audit and/or a single audit.

The PIHP must submit to MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end.

PIHPs/CMHSPs are obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the State's BBA- compliant Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: 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 MDHHS's Division of QMP annually. Although the report does not specifically look at HSW services, because HSW enrollees represent a sizable proportion of people served who have intellectual/developmental disabilities, the report is used to note overall trends.

In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend $750,000 or more in federal awards during their fiscal year must submit to MDHHS a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to PIHPs. The 834 process generates an enrollment file based upon the PIHP provider ID number and the beneficiary's assignment to the CWP Managed Care benefit plan. This process uses edits to assure only the PIHPs that have a contract with the State are provided the capitation payment for the CWP. Each PIHP has a unique state-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to a contracted PIHP. This process includes verifying the participant's Medicaid eligibility and CWP benefit plan. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PIHP using the Medicaid Management Information System (MMIS). MDHHS utilizes a six month retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 process.

The repayment and recoupment processes are for the capture and correction of funds for beneficiaries who enrolled or disenrolled in the PIHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the CWP during a given month when the PIHP did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for beneficiaries who disenrolled from the CWP but the PIHPs received capitation payments due to data lags in the 834 process.

MDHHS has developed a report in the CWP database to monitor participants who are not receiving any CWP services.

Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's participants.

c) The PIHPs are responsible for having independent audits completed as noted above. At the state level, the MDHHS Office of Audit and the MDHHS-BHDDA Bureau of Community Mental Health Services review the reports, issue management decisions, and follow-up as needed.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of encounters submitted to MDHHS with all required data elements. Numerator: Number of encounters submitted to MDHHS with all required data elements. Denominator: Number of all encounters submitted to MDHHS.

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of capitation payments made to the PIHPs only for waiver participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHPs for waiver participants with active Medicaid. Denominator: Total number of all waiver capitation payments.

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Number of capitation payments made to PIHPs at the approve rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
CHAMPS

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

Data Aggregation and Analysis:

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

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

The Federal Compliance Site Review includes an examination of the participant's IPOS and the supporting documentation that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS.

b. Methods for Remediation/Fixing Individual Problems

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

Because this is a capitation payment system based upon encounters, payments are processed on a monthly basis with a rolling quarter look-back. If individual payment issues are noted by the PIHP, it contacts MDHHS to investigate and correct the payment if applicable. This process generally is completed within one payment month.

MDHHS Office of Audit reviews the Financial Statement Audit and Compliance Examination Reports. When irregularities are found, the PIHP must submit a Corrective Action Plan. The MDHHS Office of Audit or MDHHS-BHDDA Bureau of Community Mental Health issues a management decision regarding whether the corrective action plan is sufficient to address the issues. If the plan is not sufficient to correct the issue, it would be addressed in the management decision letter as to why the corrective action plan is not sufficient and what further corrective action is required. Follow-up by MDHHS requires the PIHP to report on the current status toward correction and implementation of the plan. In addition to this process, the MDHHS-BHDDA Division of Program Development, Consultation, and Contracts may provide technical assistance to PIHPs to help in correcting financial irregularities and assuring fiscal integrity in accordance with OMB Circular A-87.

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

If the Federal Compliance site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by MDHHS-BHDDA.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

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

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

This §1915(c) waiver operates concurrently with the state's §1115 waiver. Please refer to the Michigan's approved §1115 Managed Specialty Service and Supports waiver application and associated materials.

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

The PIHP contracted providers submit CWP services encounters/claims to the PIHPs; the clean claims are then adjudicated and paid [out of the PIHP's capitation funds] within the payment timeliness parameters specified in their PIHP contracts; the definition of clean claim, the flow of billings, and the payment timeliness parameters, etc. are governed by the MDHHS/PIHP contract.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one):*

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

Select at least one:

- [ ] ***Certified Public Expenditures (CPE) of State Public Agencies.***

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

☒ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

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

a) For this waiver, the PIHP incurs certified public expenditures (and is a CMHSP, which is a local government agency).
b) The PIHPs collect and calculate actual cost data and attest to the fact that the data reporting is accurate. Costs are reported through various financial documents both throughout the fiscal year and at the close of the fiscal year and are subject to annual auditing to assure that the CPE is based on total computable costs for the concurrent 1115/c waiver.
c)Expenditures are based on eligibility, reporting of encounters for the provision of valid waiver services and the cost for providing those services. CHAMPS verifies eligibility and checks for encounters. Annual audit compliance exams are used to verify that the CPE are properly identified, categorized, distributed, and reported by fund source are eligible for FFP. MDHHS reviews the annual compliance exam to assure that any irregularities are addressed by the PIHP.

Appendix I: Financial Accountability

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

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

The quarterly CMS 64 Claims for federal financial participation for this waiver program are made based on the monthly §1915(c) waiver capitation payments made to the PIHPs on behalf of the participants enrolled in this waiver program.

a) These capitation payments are made only after each participant's active Medicaid eligibility has been verified through CHAMPS. Per the performance measure in the QIS for this appendix, a representative random sample of all CWP participants is reviewed to assure that capitation payments are made only for CWP participants with active Medicaid eligibility.

b) The QMP Site Review Team reviews a proportionate random sample of CWP participants during each comprehensive full review. This review includes an examination of the participant's IPOS and the supporting documentation (e.g., progress notes, time sheets, claims from providers to the PIHP, or any other relevant evidence) that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS. This is reflected in a performance measure in the QIS for Appendix D.

The MDHHS/PIHP contract specifies the Claims Management requirements incumbent upon the PIHPs and the providers within their networks. It is the encounter and cost data governed by these claims management requirements that constitutes the data basis from which the State's actuary develops the capitation rates for this waiver program's participants.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

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

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

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

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

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

As noted in I-1, the CWP database is the system of record for enrollment into the waiver. On a monthly basis, enrollment data and associated payment elements, such as the residential living arrangement, are interfaced from the CWP database to CHAMPS. If the CWP participant is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the CWP benefit plan is opened. If the CWP participant is non-Medicaid eligible, notification is sent back to the CWP database advising that a particular record did not process for payment and must be resubmitted next cycle. If the CWP benefit plan is open, the PIHP receives an electronic member file containing CWP enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the CWP participant has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the CWP capitation payments are made by MDHHS to the PIHPs' accounts and a payment record is issued to the PIHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions

that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

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

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

Appendix I: Financial Accountability

I-3: Payment *(3 of 7)*

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

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

I-3: Payment *(4 of 7)*

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

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

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

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

PIHPs are the lead CMHSPs, which are local governmental entities. The PIHPs receive capitation payments and furnish, either directly or through contracts with networks of qualified providers, the full array of this waiver's services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

Describe the recoupment process:

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the §1915(c)/1115 concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the §1915(c)/1115 concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments***

to a governmental agency.

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

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

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

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***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.***

◉ ***This waiver is a part of a concurrent ?1115/?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 ?1115 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:

☐ ***Other State Level Source(s) of Funds.***

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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

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

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

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

Section 428 of the current year Appropriation Act states: Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

a) County governments have the authority to levy taxes. CMHSPs may receive county appropriations or other revenues described below.

b) Per the MDHHS/CMHSP contract, the sources of other revenue are described in Section 7.0 Contract Financing. The revenue sources include county appropriations, other appropriations and service revenues, gifts and contributions, special fund account, investment interest, and other revenues for mental health.

c) The mechanism used to transfer funds to the Medicaid Agency is an intergovernmental transfer, specifically, the PIHP shall provide to MDHHS on a quarterly basis the PIHP obligation for local funds as a bon fide source of match for Medicaid.

☒ ***Other Local Government Level Source(s) of Funds.***

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

Not applicable

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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

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

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

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

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

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home***

of the individual.

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

The requirement to exclude room and board costs from Medicaid payments is stated in the Michigan Medicaid Provider Manual, as well as within the MDHHS Contract with the PIHPs. the PIHPs pay for CWP services. The other costs of the subcontractor residential provider, including room and board, can only be paid by using SSI or state general fund dollars.

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

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

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	43758.45	12650.00	56408.45	89962.00	2849.00	92811.00	36402.55
2	39458.34	12903.00	52361.34	91311.00	2906.00	94217.00	41855.66
3	36593.73	13161.00	49754.73	92681.00	2965.00	95646.00	45891.27
4	37159.84	13424.00	50583.84	94071.00	3024.00	97095.00	46511.16
5	37727.21	13692.00	51419.21	95482.00	3084.00	98566.00	47146.79

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	469	469
Year 2	519	519
Year 3	569	569
Year 4	569	569
Year 5	569	569

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) has been projected based on actual experience from recent historical experience, reflecting year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count. The ALOS is calculated based on actual experience through September 2018 and estimated phase-in and phase-out assumptions for future time periods. Changes in ALOS over the course of the 5-year renewal period are based on projected changes in enrollees over the waiver period and reflecting slightly shorter stays if more people phase into the waiver than phase out in a given year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

following factors.

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

We have updated the base experience from the previously filed and approved waiver amendment to reflect SFY 2016 experience. Factor D for the new 5-year waiver period for the renewal (October 1, 2019 through September 30, 2024) was projected from SFY 2018 of the current period data in the following manner:
Base number of users was calculated by determining the allocated number of users from the historical experience. The percentage of members identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant counts to determine the number of users across the 5-year renewal period. Therefore, a projected number of users for WY 1 represents projected experience for SFY 2019 multiplied by the change in unduplicated participant count from to WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology.
Baseline average units per user was calculated by adjusting the historical experience of average units per user by projected growth in the ALOS. Therefore, a projected average units per user was developed by taking actual experience and multiplying by the change in ALOS to projected future time periods. The change reflected in WY 1 of the renewal period for average units per user was calculated from the projected WY 5 average units per user multiplied by the estimated change in ALOS.
Baseline average cost per unit values were calculated by adjusting the historical experience of unit cost through SFY 2018. Using the total expenditures by waiver service developed from the allocation process and dividing by the total number of units, the cost per unit was established for most of the services in the various waiver programs. Factor D was trended at a rate of 1.5% per year.
Additionally, Factor D for Waiver Years 1 through 5 were adjusted to include the following services:
Nighttime supervision services:
o Cost Assumptions –
Number of users – we estimate the number of users to be 50% of beneficiaries not residing in a licensed residential setting (identified as those who did not receive an H2016 service during the year).
Average units per user – we are assuming 50 encounters per user per year will be provided for all waiver programs.
Cost per unit – we are assuming a cost of $75 per encounter for all waiver programs to provide this 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:*

We have updated the base experience for the Factor D' expenditures from the previously filed and approved waiver amendment to reflect SFY 2018 experience. Factor D' was trended at a rate of 2.0% per year. We utilized the actual state plan service expenditures from the FFS claims and encounter data. In the prior Waiver, capitation payments were utilized for those enrolled in managed care programs. This resulted in a material increase in the Factor D' expenditures.

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

We have updated the Factor G and G' expenditures for Waiver Years 1 through 5 to be based on the following programs Factor G and G' costs that are similar to Michigan's programs:
CWP – Illinois ICF/IID experience for children age 3-21 (IL.0473.R02.02)
Factor G was trended at a rate of 1.5% per year and Factor G' was trended at a rate of 2.0% per year, consistent with Factor D and Factor D'.

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

We have updated the Factor G and G' expenditures for Waiver Years 1 through 5 to be based on the following programs Factor G and G' costs that are similar to Michigan's programs:
CWP – Illinois ICF/IID experience for children age 3-21 (IL.0473.R02.02)
Factor G was trended at a rate of 1.5% per year and Factor G' was trended at a rate of 2.0% per year, consistent with Factor D and Factor D'.

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	
Overnight Health and Safety Support	
Respite	
Enhanced Transportation	
Fiscal Intermediary	
Community Living Supports	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies	
Home Care Training, Family	
Home Care Training, Non-Family	
Specialty Service	

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
Overnight Health and Safety Support Total:							1145440.62
Overnight Health and Safety Support	☒	Encounter	278	51.00	80.79	1145440.62	
Respite Total:							4790503.92

GRAND TOTAL:	20522715.30
Total: Services included in capitation:	20522715.30
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	469
Factor D (Divide total by number of participants):	43758.45
Services included in capitation:	43758.45
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite care service - 15 minutes	☒	15 minutes	488	2073.00	4.73	4784981.52	
Respite Care Service - Per Diem	☒	Per Diem	5	12.00	92.04	5522.40	
Respite	☐		0	0.00	0.01	0.00	
Enhanced Transportation Total:							0.00
Enhanced Transportation	☒	Per mile	0	0.00	0.01	0.00	
Fiscal Intermediary Total:							561516.12
Fiscal Intermediary	☒	Per month	342	11.00	149.26	561516.12	
Community Living Supports Total:							12848367.27
CLS	☒	15 minutes	499	5087.00	4.95	12565144.35	
CLS, Unlicensed	☒	Per Diem	2	18.00	178.55	6427.80	
CLS, Licensed	☒	Per Diem	14	42.00	470.74	276795.12	
Community Living Supports	☐		0	0.00	0.01	0.00	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:							117817.13
Specialized supply (NOS)	☒	item	1	5.00	225.81	1129.05	
Durable medical equipment (DME), misc.	☒	item	33	2.00	561.11	37033.26	
Vehicle modifications	☒	item	5	1.00	9706.02	48530.10	
Specialized medical equipment (NOS)	☒	item	2	2.00	4694.42	18777.68	
Personal care item (NOS)	☒	item	232	887.00	0.06	12347.04	

GRAND TOTAL:	20522715.30
Total: Services included in capitation:	20522715.30
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	469
Factor D (Divide total by number of participants):	43758.45
Services included in capitation:	43758.45
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Family Total:							**216773.76**
Home Care Training, Family	☒	Encounter	254	7.00	121.92	**216773.76**	
Home Care Training, Non-Family Total:							**117936.00**
Home Care Training, Non-Family	☒	Encounter	270	5.00	87.36	**117936.00**	
Specialty Service Total:							**724360.48**
Activity Therapy - Art, Music, Recreation	☒	session	200	36.00	92.32	**664704.00**	
Massage Therapy	☒	15 minutes	58	52.00	19.78	**59656.48**	

GRAND TOTAL:	**20522715.30**
Total: Services included in capitation:	20522715.30
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**469**
Factor D (Divide total by number of participants):	**43758.45**
Services included in capitation:	43758.45
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	327

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight Health and Safety Support Total:							**1145440.62**
Overnight Health and Safety Support	☒	Encounter	278	51.00	80.79	**1145440.62**	
Respite Total:							**4790503.92**

GRAND TOTAL:	**20478877.94**
Total: Services included in capitation:	20478877.94
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**519**
Factor D (Divide total by number of participants):	**39458.34**
Services included in capitation:	39458.34
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite care service - 15 minutes	☒	15 minutes	488	2073.00	4.73	4784981.52	
Respite Care Service - Per Diem	☒	Per Diem	5	12.00	92.04	5522.40	
Respite	☐		0	0.00	0.01	0.00	
Enhanced Transportation Total:							0.00
Enhanced Transportation	☒	mile	0	0.00	0.36	0.00	
Fiscal Intermediary Total:							561516.12
Fiscal Intermediary	☒	month	342	11.00	149.26	561516.12	
Community Living Supports Total:							12848367.27
CLS	☒	15 minutes	499	5087.00	4.95	12565144.35	
CLS, Unlicensed	☒	Per Diem	2	18.00	178.55	6427.80	
CLS, Licensed	☒	Per Diem	14	42.00	470.74	276795.12	
Community Living Supports	☐		0	0.00	0.01	0.00	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:							70726.03
Specialized supply (NOS)	☒	item	1	5.00	225.81	1129.05	
Durable medical equipment (DME), misc.	☒	item	33	2.00	561.11	37033.26	
Vehicle modifications	☒	service	1	1.00	1439.00	1439.00	
Specialized medical equipment (NOS)	☒	item	2	2.00	4694.42	18777.68	
Personal care item (NOS)	☒	item	232	887.00	0.06	12347.04	

GRAND TOTAL:	20478877.94
Total: Services included in capitation:	20478877.94
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	519
Factor D (Divide total by number of participants):	39458.34
Services included in capitation:	39458.34
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Family Total:							**220027.50**
Home Care Training, Family	☒	session	254	7.00	123.75	**220027.50**	
Home Care Training, Non-Family Total:							**117936.00**
Home Care Training, Non-Family	☒	session	270	5.00	87.36	**117936.00**	
Specialty Service Total:							**724360.48**
Activity Therapy - Art, Music, Recreation	☒	session	200	36.00	92.32	**664704.00**	
Massage Therapy	☒	15 minutes	58	52.00	19.78	**59656.48**	

GRAND TOTAL:	**20478877.94**
Total: Services included in capitation:	20478877.94
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**519**
Factor D (Divide total by number of participants):	**39458.34**
Services included in capitation:	39458.34
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	327

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight Health and Safety Support Total:							**1162596.00**
Overnight Health and Safety Support	☒	Encounter	278	51.00	82.00	**1162596.00**	
Respite Total:							**4861400.40**

GRAND TOTAL:	**20821833.13**
Total: Services included in capitation:	20821833.13
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**569**
Factor D (Divide total by number of participants):	**36593.73**
Services included in capitation:	36593.73
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite care service - 15 minutes	☒	15 minutes	488	2073.00	4.80	4855795.20	
Respite Care Service - Per Diem	☒	Per Diem	5	12.00	93.42	5605.20	
Respite	☒		0	0.00	0.01	0.00	
Enhanced Transportation Total:							0.00
Enhanced Transportation	☒	mile	0	0.00	0.36	0.00	
Fiscal Intermediary Total:							569943.00
Fiscal Intermediary	☒	month	342	11.00	151.50	569943.00	
Community Living Supports Total:							13030303.94
CLS	☒	15 minutes	499	5087.00	5.02	12742833.26	
CLS, Unlicensed	☒	Per Diem	2	18.00	181.23	6524.28	
CLS, Licensed	☒	Per Diem	14	42.00	477.80	280946.40	
Community Living Supports	☒		0	0.00	0.01	0.00	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:							119349.43
Specialized supply (NOS)	☒	item	1	5.00	229.20	1146.00	
Durable medical equipment (DME), misc.	☒	item	33	2.00	569.53	37588.98	
Vehicle modifications	☒	service	5	1.00	9841.61	49208.05	
Specialized medical equipment (NOS)	☒	item	2	2.00	4764.84	19059.36	
Personal care item (NOS)	☒	item	232	887.00	0.06	12347.04	

GRAND TOTAL:	20821833.13
Total: Services included in capitation:	20821833.13
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	569
Factor D (Divide total by number of participants):	36593.73
Services included in capitation:	36593.73
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Family Total:							**223334.58**
Home Care Training, Family	☒	session	254	7.00	125.61	**223334.58**	
Home Care Training, Non-Family Total:							**119704.50**
Home Care Training, Non-Family	☒	session	270	5.00	88.67	**119704.50**	
Specialty Service Total:							**735201.28**
Activity Therapy - Art, Music, Recreation	☒	session	200	36.00	93.70	**674640.00**	
Massage Therapy	☒	15 minutes	58	52.00	20.08	**60561.28**	

GRAND TOTAL:	**20821833.13**
Total: Services included in capitation:	20821833.13
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**569**
Factor D (Divide total by number of participants):	**36593.73**
Services included in capitation:	36593.73
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight Health and Safety Support Total:							**1180034.94**
Overnight Health and Safety Support	☒	Encounter	278	51.00	83.23	**1180034.94**	
Respite Total:							**4932298.08**

GRAND TOTAL:	**21143946.92**
Total: Services included in capitation:	21143946.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**569**
Factor D (Divide total by number of participants):	**37159.84**
Services included in capitation:	37159.84
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite care service - 15 minutes	☒	15 minutes	488	2073.00	4.87	4926608.88	
Respite Care Service - Per Diem	☒	Per Diem	5	12.00	94.82	5689.20	
Respite	☒		0	0.00	0.01	0.00	
Enhanced Transportation Total:							0.00
Enhanced Transportation	☒	mile	0	0.00	0.01	0.00	
Fiscal Intermediary Total:							578482.74
Fiscal Intermediary	☒	month	342	11.00	153.77	578482.74	
Community Living Supports Total:							13237690.86
CLS	☒	15 minutes	499	5087.00	5.10	12945906.30	
CLS, Unlicensed	☒	Per Diem	2	18.00	183.95	6622.20	
CLS, Licensed	☒	Per Diem	14	42.00	484.97	285162.36	
Community Living Supports	☒		0	0.00	0.01	0.00	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:							121005.00
Specialized supply (NOS)	☒	item	1	5.00	232.64	1163.20	
Durable medical equipment (DME), misc.	☒	item	33	2.00	578.07	38152.62	
Vehicle modifications	☒	item	5	1.00	9999.38	49996.90	
Specialized medical equipment (NOS)	☒	item	2	2.00	4836.31	19345.24	
Personal care item (NOS)	☒	item	232	887.00	0.06	12347.04	

GRAND TOTAL:	21143946.92
Total: Services included in capitation:	21143946.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	569
Factor D (Divide total by number of participants):	37159.84
Services included in capitation:	37159.84
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Family Total:							**226677.22**
Home Care Training, Family	☒	session	254	7.00	127.49	**226677.22**	
Home Care Training, Non-Family Total:							**121500.00**
Home Care Training, Non-Family	☒	session	270	5.00	90.00	**121500.00**	
Specialty Service Total:							**746258.08**
Activity Therapy - Art, Music, Recreation	☒	session	200	36.00	95.11	**684792.00**	
Massage Therapy	☒	15 minutes	58	52.00	20.38	**61466.08**	

GRAND TOTAL:	**21143946.92**
Total: Services included in capitation:	21143946.92
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**569**
Factor D (Divide total by number of participants):	**37159.84**
Services included in capitation:	37159.84
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight Health and Safety Support Total:							**1197757.44**
Overnight Health and Safety Support	☒	Encounter	278	51.00	84.48	**1197757.44**	
Respite Total:							**5003196.96**

GRAND TOTAL:	**21466784.90**
Total: Services included in capitation:	21466784.90
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**569**
Factor D (Divide total by number of participants):	**37727.21**
Services included in capitation:	37727.21
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite care service - 15 minutes	☒	15 minutes	488	2073.00	4.94	4997422.56	
Respite Care Service - Per Diem	☒	Per Diem	5	12.00	96.24	5774.40	
Respite	☒		0	0.01	0.01	0.00	
Enhanced Transportation Total:							0.00
Enhanced Transportation	☒	mile	0	0.00	0.01	0.00	
Fiscal Intermediary Total:							587172.96
Fiscal Intermediary	☒	month	342	11.00	156.08	587172.96	
Community Living Supports Total:							13445138.02
CLS	☒	15 minutes	499	5087.00	5.18	13148979.34	
CLS, Unlicensed	☒	Per Diem	2	18.00	186.71	6721.56	
CLS, Licensed	☒	Per Diem	14	42.00	492.24	289437.12	
Community Living Supports	☒		0	0.00	0.01	0.00	
Environmental Accessibility Adaptations and Specialized Medical Equipment & Supplies Total:							122634.78
Specialized supply (NOS)	☒	item	1	5.00	236.13	1180.65	
Durable medical equipment (DME), misc.	☒	item	33	2.00	586.74	38724.84	
Vehicle modifications	☒	item	5	1.00	10149.37	50746.85	
Specialized medical equipment (NOS)	☒	item	2	2.00	4908.85	19635.40	
Personal care item (NOS)	☒	item	232	887.00	0.06	12347.04	

GRAND TOTAL:	21466784.90
Total: Services included in capitation:	21466784.90
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	569
Factor D (Divide total by number of participants):	37727.21
Services included in capitation:	37727.21
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Family Total:							**230073.20**
Home Care Training, Family	☒	session	254	7.00	129.40	**230073.20**	
Home Care Training, Non-Family Total:							**123322.50**
Home Care Training, Non-Family	☒	session	270	5.00	91.35	**123322.50**	
Specialty Service Total:							**757489.04**
Activity Therapy - Art, Music, Recreation	☒	session	200	36.00	96.54	**695088.00**	
Massage Therapy	☒	15 minutes	58	52.00	20.69	**62401.04**	

GRAND TOTAL:	**21466784.90**
Total: Services included in capitation:	21466784.90
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**569**
Factor D (Divide total by number of participants):	**37727.21**
Services included in capitation:	37727.21
Services not included in capitation:	
Average Length of Stay on the Waiver:	327