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 SEDW is transitioning from fee-for-service to managed care. Also, the SEDW is currently limited to thirty-seven counties and twenty-five CMHSPs. Michigan is requesting to add the remaining 46 counties to the geographic region for the SEDW which will result in the SEDW being available for the entire state of Michigan.

Michigan is adding two services (Fiscal Intermediary and Overnight Health and Safety Support)to the SEDW array of covered services.

Michigan is also eliminating Transitional Services as an SEDW covered service. This service is under utilized, the service is actually never utilized. Michigan believes this service which is a one-time-only expense is accessed by family's via other benefits

or resources.

MDHHS transition plan includes an SEDW orientation webinar, in-person SEDW operations training at each PIHP for SEDW Leads at the PIHPs and CMHSPs, identifying and training SEDW Leads at each local MDHHS office, Waiver Support Application(WSA) training and a kick-off webinar just prior to implementation to cover updates and any lingering 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*):

Waiver for Children with Serious Emotional Disturbances

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.0438
Draft ID: MI.004.03.00

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 and Healthy Michigan.

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 Waiver for Children with Serious Emotional Disturbance (SEDW) provides services that are additions to Medicaid State Plan coverage for children with SED who are enrolled in the SEDW, up to the child's 21st birthday. This waiver permits the State to provide an array of community based services to enable children who would otherwise require hospitalization in our State Psychiatric hospital for children (Hawthorn Center) to remain in their home and community.

The MDHHS operates the SEDW through contracts with the Regional Prepaid Inpatient Health Plans (PIHP). Oversight of the SEDW is provided by MDHHS, which is the Single State Medicaid Agency. Two administrations within MDHHS-Behavioral Health and Developmental Disabilities Administration (BHDDA) and the Medical Services Administration (MSA) have responsibility for operations and payments, respectively. The SEDW is a Medicaid managed care program administered locally by Prepaid Inpatient Health Plans (PIHPs); and which is contracted by MDHHS as providers of services to SEDW enrollees under the auspices of a §1915(c) Managed Care contract. Services are provided directly by PIHPs in partnership with CMHSPs their contracted providers and other community agencies. When medically necessary, SEDW 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 SEDW may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

Application for the SEDW is made through the PIHP. The PIHP is responsible for the coordination of SEDW services. The Wraparound Facilitator, the child and his/her family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in an Individual Plan of Services (IPOS).

To be eligible for this waiver, the child/youth must:
Meet current MDHHS criteria for admission to the state psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual; AND
Demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®) or the Devereux Early Childhood Assessment Scales (DECA):
CAFAS® score of 90 or greater for children age 7 to 12; OR
CAFAS® score of 120 or greater for children age 13 to 18; OR
For children age 3 to 7, elevated PECFAS® subscale scores(20 is considered an elevated subscale score)in at least one of these areas:
self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; OR
For children age 2-4, scores in the concern range across Devereux Early Childhood Assessment (DECA) Clinical Version scales: Protective factor scales (initiative, self control, and attachment) that are in the Concern Range with a Total Protective Factor T-Score of 40 or below and/or elevated scores on one or more of the behavioral concerns scales (Attention Problems, Aggression, Withdrawal/Depression, Emotional Control Problems) with a T-score of 60 or above.
The participant must live in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services.
Meet Medicaid eligibility criteria and become a Medicaid beneficiary; OR
Be under age 18, residing in a foster home with a permanency plan; OR
Living full time in the community with their birth or adoptive parent or with a legal guardian and eligible for Medicaid as a “family-of-one.”
Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, and continues to meet all non-age related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.
Participant must receive Wraparound.

Participants must receive at least one SED waiver service per month in addition to Wraparound contacts in order to retain eligibility. The exception to this requirement occurs during the final 30-60 days of SEDW enrollment when the child and family transition from both Wraparound and the SEDW at the same time.

Services for Children with Serious Emotional Disturbance:
Community Living Supports
Family Support and Training
Non-Family Training
Children’s Therapeutic Foster Care
Therapeutic Overnight Camping
Wraparound
Specialty Therapies (Music, Recreational and Art)
Family Training
Respite

Fiscal Intermediary
Overnight Health and Safety Support

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:

The SEDW program is fully described on Michigan's Department of Health and Human Services (MDHHS)Website, including contact numbers and email addresses to request additional information and to provide feedback. Responses to inquiries are frequent and are provided by the SEDW Director, Specialist and Analyst. The Michigan Medicaid Provider Manual also details the SEDW and is available on the MDHHS website. Elements of the SEDW are covered in trainings, presentations, and conferences, which are conducted throughout the state on a regular basis to a variety of stakeholders including: County Commissions, Department of Health and Human Services Directors, Community Mental Health Directors, Children's Clinical Services Director's, Judges, Probation Officers, Representatives of Special Education, and other service providers, advocacy groups, as well as consumers and their families. Additionally, site reviews by MDHHS staff include home visits which provide a valuable opportunity for families to express their views of the waiver, it's services, and the impact on their lives. Communication was sent to all the PIHPs and CMHSPs informing them of MDHHS's intent to renew the SEDW waiver.

On December 19, 2018, MDHHS sent a notice of intent to renew the SEDW to all PIHP Executive Directors and CMHSP SEDW Lead Person(s).

On April 15, 2019, a notice of intent to submit a request to renew the SEDW was sent to Tribal Chairs and Health Directors, notice ends on June 15, 2019. The letter is posted on the MDHHS website. Public notice was submitted on May 15, 2019, notice ends on June 15, 2019.

The proposed waiver applications may be viewed at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health & Developmental Disability >> Mental Health.

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

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

7. Contact Person(s)

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

Last Name: Coleman

First Name: Jacqueline

Title: Waiver Specialist

Agency: Medical Services Administration, Michigan Department of Community Health

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: Stiffler

First Name: Kathleen A.

Title: Acting Director

Agency: Medical Services Administration

Address: 400 South Pine Street

Address 2: P.O. Box 30479

City: Lansing

State: **Michigan**

Zip: 48909

Phone:

(517) 241-9944 **Ext:** ☐ **TTY**

Fax:

(517) 335-5007

E-mail:

SifflerK@michigan.gov

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 SEDW is transitioning from fee-for-service to managed care. The SEDW is currently limited to thirty-seven counties and twenty-five CMHSPs. Michigan is requesting to add the remaining 46 counties to the geographic region for the SEDW which will result in the SEDW being available for the entire state of Michigan.

Michigan is adding two services (Fiscal Intermediary and Overnight Health and Safety Support)to the SEDW array of covered services.

Participants will be notified of these changes during the public notice and tribal notice process.

Michigan is also eliminating Transitional Services as an SEDW covered service. This service is under utilized, the service is actually never utilized. Michigan believes this service which is a one-time-only expense is accessed by family's via other benefits or resources. This transition will occur with the approval of the renewal application. Participants will be notified of this change during the public notice and tribal notice process. The health and welfare of consumers who receive this one-time-only service will be assured based on access to this service through other services and supports.

MDHHS transition plan includes an SEDW orientation webinar, in-person SEDW operations training at each PIHP for SEDW Leads at the PIHPs and CMHSPs, identifying and training SEDW Leads at each local MDHHS office, Waiver Support Application(WSA) training and a kick-off webinar just prior to implementation to cover updates and any lingering questions.

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 all settings under this waiver should be presumed to be compliant with the rule. All children under this waiver program are served in family homes, independent living settings, or foster family homes. The State of Michigan licensing rules governing child foster family homes and group foster family homes to
ensure that the children placed in these settings are treated the same as any other children in the home and that the licensing rules fully comport with 42 CFR §441.301(c)(4). Due to the characteristics of these settings and the requirements under state licensing, MDHHS has determined that these settings meet the requirements of the rule.

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 (MDHHS)-Behavioral Health/Developmental Disabilities

(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:

The Michigan Department of Health (MDHHS) is the single State Medicaid Agency and is comprised of three administrations: The Medical Services Administration (MSA), which administers Medicaid for MDHHS; the Behavioral Health and Developmental Disabilities Administration (BHDDA) Administration, which operates the Waiver for Children with Serious Emotional Disturbances (SEDW) 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 SEDW including review and approval of initial waiver applications and renewal certifications submitted by Regional Prepaid Inpatient Health Plans (PIHPs), SEDW 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 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/re-evaluation activities, conduct site reviews, conduct training and technical assistance, provide input for updating the Medicaid Provider Manual concerning waiver requirements and implementation.

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 SEDW is within the MDHHS-BHDDA Bureau of Community Based Services.

The MDHHS Director oversees and provides guidance related to the administration and operation of the SEDW through regular and as-needed (if issues arise) contacts with the directors of MDHHS-BHDDA and MDHHS-MSA. While the administration of the waiver falls within the jurisdiction of the MDHHS-BHDDA, all reports, amendments, renewals, and applications for the waivers are reviewed, approved and then submitted to CMS by the State Medicaid Director within MSA.

The Memorandum of Understanding between MSA and BHDDA outlines the responsibilities for administration and oversight of the waiver. As indicated in a) above, the responsibilities of the BHDDA include: monitoring and managing the annual SEDW appropriation; managing waiver enrollment against approved limits; performing prior authorization of selected services for the SEDW; establishing eligibility for the SEDW; conducting and monitoring quality assurance at the PIHP/CMHSP level; providing training and technical assistance concerning waiver requirements; completing waiver applications, renewals, amendments and 372 reports related to the SEDW (which are then submitted to MSA for review and approval). The responsibilities of the MSA include: establishing fee screens; setting and publishing Medicaid policy, including policy related to the SEDW; determining Medicaid eligibility; reviewing, approving and submitting waiver applications, renewals, amendments and 372 reports to CMS; processing Medicaid claims and make payments based on established methodology. If the Medicaid Director has a concern as to how BHDDA fulfills their responsibility as outlined in the MOU, he/she would take concerns to the BHDDA Director.

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

Appendix A: Waiver Administration and Operation

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

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

Michigan operates a concurrent §1115 Pathway to Integration waiver with the §1915(c) waiver. 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; conducting level of care evaluation activities for re- certifications; assuring participants have been given freedom of choice of providers and have consented to SEDW services in lieu of Institutional Level of Care; 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 SEDW 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:

MDHHS currently contracts with local/regional non-state public entities known as Community Mental Health Services Programs (CMHSP) established under the authority of the Michigan Mental Health Code. The concurrent §1915(b)(4) waiver allows for selectively contracting with Community Mental Health Services Programs (CMHSP) as the provider of services to SEDW consumers effective 4/1/2012. With this application MDHHS is transitioning from contracting with CMHSPs to contracting with the Regional Prepaid Inpatient Health Plans (PIHPs). PIHPs will be delegated the responsibility to perform the following activities and functions: disseminating information concerning the waiver to potential enrollees; assisting consumers in applying for needed mental health services, including assessment of eligibility for the SEDW; conducting initial level of care evaluations and level-of-care re-evaluations; assuring that consumers have been given a waiver services in lieu of Psychiatric Hospital care; that consumers have choice among service providers who are under contract with or employed by the PIHP/CMHSP; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the consumer's needs; conducting prior authorization and utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining a network of qualified providers sufficient to meet the consumers' needs.

☐ **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 are organized in a way that addresses the functions delegated by MDHHS to the participating PIHPs for the SEDW. 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. 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 MDHHS-BHDDA, the Division of Quality Management and Planning division, monitors implementation of the §1915(c) SED waiver by PIHPs. The Quality Management Planning division has responsibility for performing on-site reviews at each of the approved participating PIHPs. MDHHS sends a qualified site review team to each PIHP and 46 CMHSPs to conduct comprehensive biennial site reviews to ensure that Michigan's 1915(c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all consumers served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of waiver consumers'.

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

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:
• Includes services and supports that align with and address all assessed needs
• addresses health and safety risks
• is developed in accordance with MDHHS policy and procedures, including utilizing person centered/family focused planning
• is updated at least annually

Clinical record reviews are also completed to determine that participants are afforded choice between services and institutional care and between/among service providers and that services are provided as identified in the IPOS. MDHHS site review staff conducts consumer interviews with at least one child and family whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews may be conducted in the provider's office, over the telephone or at the child's home.

A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDHHS in 30 days. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

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

Within MDHHS-BHDDA, the Bureau of Community Mental Health Services has responsibility for operation of the SEDW on a day-to-day basis. This includes: monitoring and managing the SEDW annual appropriation; managing waiver enrollment against approved limits; establishing clinical eligibility for the waiver; conducting and monitoring quality assurance at the PIHP/CMHSP level; providing training and technical assistance concerning waiver requirements; completing SEDW renewal applications, amendments and CMS-372 reports for submission to CMS; reviewing and consulting with PIHPs/CMHSPs when the Site Review Team has identified issues related to delegated functions; monitoring health and welfare issues by way of recipient rights complaints, Critical Incidents and Medicaid fair hearing requests.

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	Local Non-State 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 PIHPs that implement quality assurance/improvement activities as required by contract. Numerator: Number of PIHPs that implement required quality assurance/improvement activities.

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **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**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

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

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 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 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 Division of Quality Management and Planning (QMP) within MDHHS monitors the implementation at the PIHPs (comprised of all 46 CMHSPs). MDHHS sends a qualified site review team to each PIHP and 46 CMHSPs to conduct comprehensive biennial site reviews to ensure that Michigan's 1915 (c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all consumers served by Michigan's Section 1915 (c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers'.

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

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

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

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

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

A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDHHS in 30 days. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

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

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

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.

A standard site review protocol is used at the time of the site visit. The protocol is used to record and document findings during a site review. The findings are sent to the CMHSPs with the requirement that the CMHSP prepare and submit to MDHHS plans of correction within 30 days. The plans of correction are reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. The remediation process continues until all concerns have been appropriately addressed.

ii. Remediation Data Aggregation

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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					
	☐	Mental Illness			☐
	☒	Serious Emotional Disturbance	0	21	

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

Meet current MDHHS criteria for admission to the state psychiatric hospital for children, as defined in the Michigan Medicaid Provider Manual; AND Demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®) or the Devereux Early
Childhood Assessment Scales (DECA):
CAFAS® score of 90 or greater for children age 7 to 12; OR
CAFAS® score of 120 or greater for children age 13 to 18; OR
For children age 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior
towards others; OR
For children age 2-4, scores in the concern range across Devereux Early Childhood
Assessment (DECA) Clinical Version scales: Protective factor scales (initiative, self control, and attachment) that are in the Concern Range with a Total Protective Factor T-Score of 40 or below and/or elevated scores on one or more of the behavioral concerns scales (Attention Problems, Aggression, Withdrawal/Depression, Emotional Control Problems) with a T-score of 60 or above.
The participant must live in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services.
Meet Medicaid eligibility criteria and become a Medicaid beneficiary; OR
Be under age 18, residing in a foster home with a permanency plan; OR
Living full time in the community with their birth or adoptive parent or with a legal guardian and eligible for Medicaid as a “family-of-one.”
Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, and continues to meet all non-age related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.
Participant must receive Wraparound.
Participant must receive at least one SED waiver service per month to retain eligibility.

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:

Youth that are enrolled in the 1915(c) SEDW may continue to have mental health needs that will require planning on the part of the child and family wraparound team. It is the purpose of the waiver to provide community based services and supports to increase mental health functioning across life domain areas and decrease the need for psychiatric or other mental health institutional placement.

When youth are enrolled in the SEDW, the wraparound team develops measurable outcomes that guide the team toward transition or graduation from wraparound and enrolled waiver status. As stated above, this does not always mean that they no longer need any type of mental health services rather that they typically need less intensive services from intake to graduation.
As a youth approaches his/her early adult years, the child and family team focus on planning for this period of transition. There are many things to consider during this time. Some of the basic issues deal with housing, employment, vocational training or school status, emotional/behavioral health, physical health and safety. During this time it is common to focus on the life domain areas that will impact the youth's success as an adult.

The team will focus on enhancing these skills utilizing Medicaid State Plan and waiver services, as well as by helping the youth and family identify and understand what services may be available post waiver. If the youth's disability impacts his/her ability to earn income, the team will work with the youth to apply for this benefit at age 18. The team will also work with the youth to identify other entitlements that would assist the youth post waiver. This is also the time that the team will explore what mental health needs the youth may have after his/her 21st birthday and start that transition process with adult services. Whenever possible we encourage the adult services staff to become part of the wraparound team to assure a smooth transition to adult services. Some CMHSPs also have programs designated for this target age group, which is optimal in assisting them toward independence.

In summary, when youth are enrolled in the waiver, transition planning starts at intake and continues until the child/youth successfully transitions. Transitions are very different for each individual, but the CMHSP assumes the responsibility that the child's/youth's needs are met post waiver. The site review process includes review of plans, including transition plans. The site review process is a strategy to identify individual and systems issues including issues related to transition planning. Transition planning for children/youth enrolled in the waiver is part of a plan of service and the wraparound planning process and is individualized to each child/youth. Many children/youth may receive services from adult mental health services or they may receive services from other systems (Vocational, housing, etc.) and this is part of
the transition planning that occurs. This planning will assist the youth/young adults in making a smooth transition to adult mental health or community based services.

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	969
Year 2	969
Year 3	969
Year 4	969

Waiver Year	Unduplicated Number of Participants
Year 5	969

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	969
Year 2	969
Year 3	969
Year 4	969
Year 5	969

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:

The waiver provides for entrance of all eligible participants through a two-tier process grounded in a Wraparound Service Facilitation and Coordination model. The Wraparound model has an infrastructure which includes the Collaborative Body, Community Team, Wraparound Facilitator, and a Child and Family Team with team members determined by the family; the wraparound plan is developed in partnership with other community agencies. Membership on the Community Team consists of administrators and mid-managers of public agencies providing services, e.g. MDHHS, CMHSP, schools, family court; parents and youth who have experienced or received services; and community members including faith-based organizations, local business people, and nonprofit administrators.

The Community Team is responsible for accepting, reviewing and approving referrals for Wraparound Services. The criteria used by the Community Team for accepting referrals for Wraparound include one or more of the following: The child is involved in multiple systems; the child is at risk of an out-of-home placement, or is currently in out-of-home placement; the child and family have received other community services and supports with minimal improvement; and numerous providers are serving multiple children in the family, and service outcomes have not been met.

When an individual is determined by the Community Team to be eligible for Wraparound Services, a further review is conducted to determine if the child also appears to meet criteria for the SEDW. If so, the Community Team makes a referral to the PIHP. The PIHP assesses eligibility, including if the individual meets the level-of-care (LOC) for the SEDW. This determination is based on two things: whether the individual meets the criteria for and is at risk of hospitalization in a state psychiatric hospital, as defined in the Michigan Medicaid Provider Manual; and whether the child demonstrates serious functional limitations that impair his/her ability to perform in the community. As part of this process, the PIHP determines level of functional limitation using the Child and Adolescent Functional Assessment Scale (CAFAS), the Preschool and Early Childhood Functional Assessment Scale (PECFAS) or the Devereux Early Childhood Assessment Scales (DECA), as appropriate for age. For those individuals meeting the LOC for the waiver, the PIHP discusses choice of waiver services over hospitalization with the family, completes a Waiver Certification and application for each candidate and submits it to MDHHS via the Waiver Support Application (WSA) for review, approval, and enrollment in the waiver.

Although PIHPs typically receive referrals for the SEDW from the Community Team, a family could make a request for the SEDW directly to the PIHP. In this case, the PIHP would proceed with determining if the individual meets eligibility criteria for the waiver, including LOC. In this way, an evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed. MDHHS will educate PIHPs on how to respond to direct requests for the SEDW. PIHPs intake/access will be made aware that the SEDW serves as a pathway to Medicaid for eligible consumers, so when a consumer makes a specific request for the SEDW, the consumer is assessed and either approved or denied. In the event of a denial (regardless if a lesser intensive service is offered) the consumer is informed of appeal rights and provided notice of appeal.

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**
- [x] **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)**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

  42 CFR §435.110, 42 CFR §435.116, 42 CFR §435.118

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:

The state is using post eligibility rules for the period between January 1, 2014 and December 31, 2018 as per Section 24.04 of the ACA. Michigan is using the same allowance for the waiver participants and amounts for medical and remedial care under spousal impoverishment post eligibly rules that it uses under the regular post eligibility rules.

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.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. 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**

◉ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **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 (6 of 7)

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

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

Answers provided in Appendix B-4 indicate that you do not need to 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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**

- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **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 formula:

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. 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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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:

An individual designated by the PIHP Director is responsible for making the initial determination of a child meeting the criteria for and is at risk of hospitalization in a state psychiatric hospital. Determination that the child demonstrates serious functional limitations that impair his/her ability to perform in the community is made by a Wraparound Facilitator or clinician who has completed training and is a reliable rater on the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®) or Devereux Early Childhood Assessment Scales (DECA). The Wraparound Facilitator or clinician must also be a Child Mental Health Professional as defined in the most recent version of the MDHHS Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes chart. The PIHP submits all initial level of care evaluations to MDHHS via the Waiver Support Application (WSA) for review, final eligibility determination, approval, and enrollment in the waiver.

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.

Level of Care (LOC) determinations are based on two things: whether the child meets the criteria for and is at risk of hospitalization in a state psychiatric hospital and whether the child demonstrates serious functional limitations that impair his/her ability to perform in the community. As appropriate for age, the level of functional limitation is identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®) or the Devereux Early Childhood Assessment Scales (DECA). Waiver eligibility requires that the child age 12 or under must have a CAFAS® score of 90 or higher, while children age 13 to 18 must have a score of 120 or higher. For children age 3 to 7, waiver eligibility requires elevated PECFAS® subscale scores (20 is considered an elevated subscale score) in at least one of these areas: self harmful behaviors, mood/emotions, thinking/communicating or behavior towards others.

Section 8.5.C of the Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual sets forth Inpatient Psychiatric Hospital Admission criteria for persons under the age of 21. It reads as follows:
Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective. Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care. The individual must meet all three criteria outlined below:
1)Severity of Illness (signs, symptoms, functional impairments and risk potential)
At least one of the following manifestations is present:
· Severe Psychiatric Signs and Symptoms
· Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
· Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
· Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial currentndysfunction.
· Disruption of Self-Care and Independent Functioning
· Beneficiary is unable to maintain adequate nutrition or self-care due to a severe psychiatric disorder.
· The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has seen a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or
severe developmental disturbance.
· Harm to Self
· A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.
· There is a specific plan to harm self with clear intent and/or lethal potential.
· There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a
history of prior attempts.
· There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.
· There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
· There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
· Harm to Others
· Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
· There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
· There has been significant destructive behavior toward property that endangers others, such as setting fires.
· The person has experienced severe side effects from using therapeutic psychotropic medications.
· Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care.
· The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization if the

condition, and the administration, adjustment or re-initiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
· There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.
2)Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the
beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.
3)Intensity of Service: The person meets the intensity of service requirements if inpatient services are considered medically
necessary and if the person requires at least one of the following:
* Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic
medications.
* Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.
* Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions)to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.
* A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

The CAFAS® is an assessment rating tool that measures functional assessment of school aged children and adolescents. Each of the PIHP/CMHSPs participating in the SEDW must also participate in the Michigan Level of Functioning Project (LOF Project), and must comply with all requirements of that project, including data collection and reporting. The CAFAS® provides an objective, reliable and valid way to identify behaviors that impair a child's functioning. Within family centered practice, the CAFAS® is best utilized when it is completed and discussed with the child/adolescent and family. In using the CAFAS®, the rater should provide a brief explanation of the CAFAS to the family, and then - working with the family - use the CAFAS® to identify needs important to the child/adolescent and family.

Additionally, the CAFAS® should help to identify strengths of the child/adolescent and family that can be used to develop a plan that will best meet the child's/adolescent's and family's needs and desires.

The PECFAS® is a standardized, validated, reliable assessment tool that measures the impairment in day-to-day functioning secondary to behavioral, emotional, psychological or psychiatric problems for children 3 to 7 years of age that have a mental health diagnosis. The PECFAS® contains a "menu" of behaviorally-oriented descriptions, from which the rater chooses those that best describe the child. The items are organized within domains of functioning (i.e. subscales), and within each domain, into levels of impairment (i.e., severe, moderate, mild, none). The domains assessed (subscales) are: school/daycare, home, community (delinquent – like behavior), behavior toward others, mood/emotions, self harmful behavior, thinking/communication.
The primary uses of the PECFAS® include:
· Identifying need for referral to mental health evaluation or services;
· Assigning cases to appropriate levels of care;
· Generating a strengths-based treatment plan;
· Active case management, using ongoing outcome information;
· Communicating with caregivers and others about child's needs; and
· Maintaining clinical documentation which can withstand audits
The PECFAS® was developed for use with children who are not yet enrolled in a full-day Kindergarten program or in first grade. Depending on the child's emotional and cognitive developmental level, the PECFAS® can be used with children ages 3 to 7 years old.
The DECA is the assessment use for children age 2-4, scores in the concern range across Devereux Early Childhood Assessment (DECA) Clinical Version scales: Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below and/or elevated scores on one or more of the behavioral concerns scales (Attention Problems, Aggression, Withdrawal/Depression, Emotional Control Problems) with a T-score of 60 or above.
The participant must live in a community-based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or

child caring institution) while receiving services. The participant must receive Wraparound and at least one other community-based Long Term Service and Support each month to maintain eligibility.

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:

Of those individuals determined eligible due to functional limitations identified by a CAFAS®, PECFAS or DECA, a further review is conducted to determine if the child meets criteria for admission to a psychiatric hospital or at risk of hospitalization in a state psychiatric hospital. If a child appears to meet these criteria, a referral is made to the PIHP for information gathering, review, preliminary eligibility determination (including family choice of waiver services over hospitalization), and possible application to the SEDW. The PIHP makes a preliminary eligibility determination for the SEDW based on the published eligibility criteria, completes the waiver application for each candidate and submits it to MDHHS via the Waiver Support Application (WSA) for review, final eligibility determination (including level of care evaluation), approval, and enrollment in the waiver.

The Wraparound Facilitator is the person responsible for the initial level of care evaluation and re-evaluations at the local level and for making a recommendation to the individual designated by the PIHP Director. The Wraparound Facilitator must be a Child Mental Health Professional and be working with the child and family.

A description of the re-evaluations process is as follows: The date of the initial SEDW enrollment is considered the re-evaluation date. If the child continues to meet SEDW criteria and to require the services of the SEDW the PIHP submits a newly executed Waiver Certification form to MDHHS. The Waiver Certification must be completed and signed within 12 months of the initial SEDW enrollment date and must be submitted to MDHHS within 30 days of signature to maintain eligibility. The PIHP also submits an updated CAFAS® summary, PECFAS® or DECA to document that the child continues to meet SEDW eligibility criteria; proof of current Medicaid eligibility; update demographics (if there have been changes); and update diagnosis information (including a brief but behavior specific comment supporting SEDW eligibility). MDHHS staff review, determine continued eligibility (including level of care reevaluation), approve the renewal application and complete and sign section 2 of the Waiver Certification form. A WSA auto-generated approval form is sent to the SEDW Lead Person for the child's file, and the Medicaid Policy office is notified that the child continues to be eligible for the SEDW.

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):*

SEDW enrollment data is maintained in the Waiver Support Application (WSA) and is used to identify children coming up for re-evaluation/recertification. The PIHP/CMHSP can access a report in the WSA that identifies when re-evaluation/recertifications are due for the children they serve. PIHP must submit a re-evaluation/recertification packet within 365 days of the previous year's certification, as stated above. MDHHS also monitors the statewide report to track past due re-evaluations/recertifications. If necessary, SEDW 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 consumer's clinical records that include the SEDW initial and re-evaluation/recertification packets, along with supporting documentation. The MDHHS maintains copies of the initial and recertification packets and approvals letters. The Medicaid agency maintains a copy of notification of both the initial and continuing eligibility for the SEDW.

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 a State Psychiatric Hospital level of care (LOC) prior to receipt of services. Numerator: Number of newly enrolled waiver consumers who have received a State Psychiatric Hospital level of care (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**
	☐ **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 365 days of their initial level of care (LOC) evaluation or their last annual LOC reevaluation. Numerator: Number of enrolled consumers who LOCs were reevaluated within 365 days 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 initial LOC evaluations where the LOC criteria was accurately applied. Numerator: Number of initial LOC evaluations where the LOC criteria was accurately applied. Denominator: All LOC evaluations.

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: Proportinate 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 LOC re-evaluations where the LOC criteria was accurately applied. Numerator: Number of LOC re-evaluations where the LOC criteria was accurately applied. Denominator: All LOC re-evaluations.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

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

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.

Level of Care (LOC) determinations are based on two things: whether the child meets the criteria for and is at risk of hospitalization in a State psychiatric hospital, and whether the child demonstrates serious functional limitations that impair his/her ability to perform in the community. The level of functional limitation is identified using the CAFAS® or PECFAS®. Eligibility for psychiatric hospitalization is documented on the Waiver Certification Form, as is the CAFAS® or the PECFAS® score. The Waiver Certification form and the CAFAS® or PECFAS® summary are submitted by the responsible CMHSP to MDHHS for review and approval at the time of the initial application and the annual re-certification. MDHHS maintains a database of all enrolled participants by CMHSP. The database identifies the initial date of eligibility for the waiver and is used to determine when re-certifications are due. A sample of the CMHSP's waiver consumer clinical records is reviewed annually via an on-site clinical and administrative record review. At this time all assessments and documentations that underpin the waiver certification are reviewed.

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.

Problems with level of care evaluation/re-evaluation are identified during the annual site review and are documented by MDHHS using the Site Review Protocol. The Provider Agency is required to respond to the MDHHS within 30 day of receipt of the report with a plan of correct. This plan of correction must be reviewed MDHHS staff that completed the site review. MDHHS administration reviews and approves staff response to the plan of correction. The remediation process continues until all concerns have been appropriately addressed.

ii. Remediation Data Aggregation

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

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

Responsible Party*(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:

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).

The Waiver Certification Form is a double-sided form with three (3) areas for completion. The third section of the Waiver Certification form is the Family Choice Assurance section, and is to be completed by the child's parent or legal guardian. This section verifies that the Wraparound Facilitator has informed the family of their right to choose between the community-based services provided by the SEDW and hospitalization in a state psychiatric hospital. The parent(s) must check one of the three choices listed in this section. This section also confirms that the family has been informed of their choice of qualified service providers. The parent/legal guardian signs and dates the "Family Choice Assurance" section of the form. The Wraparound Facilitator, as witness to the parent or guardian's signature, also signs and dates the form.

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 a copy is maintained by the PIHP in the consumer's clinical record and an electronic copy by MDHHS in the consumer record in the WSA under the Documents tab.

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 or CMHSP 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 PIHP 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 PIHPs 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 PIHPs 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	**Respite**		
Other Service	**Child Therapeutic Foster Care**		
Other Service	**Community Living Supports**		
Other Service	**Family Home Care Training**		
Other Service	**Family Support and Training**		
Other Service	**Fiscal Intermediary**		
Other Service	**Home Care Training, Non-Family**		
Other Service	**Overnight Health and Safety Support**		
Other Service	**Therapeutic Activities**		
Other Service	**Therapeutic Overnight Camp**		
Other Service	**Wraparound**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
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 is service provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations: Beneficiary's home or place of residence; family friend's home in the community; Foster home.

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

This service can be billed up to a maximum of 1248 units per month.

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Foster family home; Foster family group home
Individual	Individual respite provider
Agency	PIHP or an agency contracted to the PIHP

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Foster family home; Foster family group home

Provider Qualifications

License *(specify):*

Foster Care Providers are licensed under MCL 222.122.

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be contracted by the PIHP to provide respite services to SEDW consumers.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The 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 Foster Family Home and Foster Family Group homes are 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:

Individual respite provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications.

Frequency of Verification:

Prior to delivery of services and every two years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

PIHP or an agency contracted to the PIHP

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

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

The MDHHS/PIHP Managed Mental Health Supports and Services Contract,, specifies that the subcontract entered into by the PIHP shall address the following: a) Duty to treat and accept referrals; b) Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e) Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Child Therapeutic Foster Care

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):*

Child Therapeutic Foster Care is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:
intensive parental supervision,
positive adult-youth relationships,
reduced contact with children with challenging behaviors, and
family behavior treatment skills.
CTFC seeks to change the negative trajectory of a child's behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

In addition to being licensed, all CTFC programs under this waiver are to be pre-enrolled by MDHHS to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

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

CTFC must be billed as a 'per diem' service, up to a maximum of 365 days per year.

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	An agency contracted to the PIHP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Therapeutic Foster Care

Provider Category:
Agency
Provider Type:

An agency contracted to the PIHP

Provider Qualifications

License *(specify):*

Child Therapeutic Foster Care (CTFC) providers are licensed by the Michigan Department of Health and Human Services under MCL 722.122

Certificate *(specify):*

CTFC providers must be certified by MDHHS.

Other Standard *(specify):*

The child foster care home must be contracted by the PIHP to provide child therapeutic foster care services to SEDW consumers.

Verification of Provider Qualifications

Entity Responsible for Verification:

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.

Frequency of Verification:

The PIHP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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) are used to increase or maintain personal self-sufficiency, thus facilitating a beneficiary's achievement of his goals of community inclusion and remaining in their home. The supports may be provided in the beneficiary's home or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

CLS provides assistance to the family in the care of their child while facilitating the child's independence and integration into the community. The supports, as identified in the IPOS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living (such as personal hygiene, household chores, and socialization) may be included. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child enabling the child to attain or maintain their maximum potential. These supports may
serve to reinforce skills or lessons taught in school, therapy, or other settings.
Community Living Supports includes:
Assistance with skill development related to:
Activities of daily living (such as personal hygiene);
Household chores;
Socialization;
Improving communication and relationship-building skills; and
Participation in leisure and community activities.
Staff assistance, support and/or training with such activities as:
Improving the child's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors;
Non-medical care (i.e., not requiring nurse or physician intervention);
Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence;
Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.);
Assisting the family in relating to and caring for their child;
Attendance at medical appointments; and
Acquiring or procuring goods other than those listed as shopping and non-medical services.
Reminding, observing, rewarding and monitoring of pro-social behaviors.
Medication administration.
Staff assistance with preserving the health and safety of the beneficiary in order that he may reside or be supported in the most integrated, independent community setting.

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973, or the waiver or stat plan covered services.

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

Up to 744 units (15 minutes) per month.

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	CLS aide
Agency	PIHP or an agency contracted to the PIHP

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):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications.

Frequency of Verification:

Prior to delivery of services and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

PIHP or an agency contracted to the PIHP

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or be contracted by the PIHP to provide CLS services to SEDW consumers.
The MDHHS/PIHP Managed Mental Health Supports and Services Contract, specifies that the subcontract entered into by the PIHP shall address the following: a) Duty to treat and accept referrals; b) Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the PIHP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Direct care, aide level staff employed by the PIHP must be a responsible adult at least 18 years of age and be; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed, in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony related to the kind of duty he/she would be performing, or not an illegal alien) able to perform basic first aid procedures; and is trained in the individuals plan of service, 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 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:

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Home Care Training

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):*

Family Home Care Training provides training and counseling services for the families of beneficiaries served by this waiver. For purposes of these services, "family" is defined as the person(s) who lives with or provides care to a beneficiary served by the waiver and may include a parent and/or sibling or the foster parent(s) for a child in Therapeutic Child Foster Care. This service is provided by a Master's level social worker, psychologist, or QMHP, and includes instruction about treatment interventions and support intervention plans specified in the IPOS and includes updates as necessary to safely maintain the child at home. Family Home Care Training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and to help the child remain at home. All family training must be included in the child's IPOS and must be provided on a face-to-face basis (i.e., in person and with the family present).

This service will not be duplicative of other services provided.

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

This service must be billed per session, up to a maximum of four sessions per month.

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	Clinical professional as specified in other standard section and contracted by the PIHP.
Agency	PIHP or agency contracted to the PIHP (e.g., 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: Family Home Care Training

Provider Category:
Individual
Provider Type:

Clinical professional as specified in other standard section and contracted by the PIHP.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Service providers for Family Home Care Training must be clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Health and Human Services PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.
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:

PIHPs are responsible for verifying contract service providers' qualifications.

Frequency of Verification:

Prior to delivery of service and every two years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PIHP or agency contracted to the PIHP (e.g., clinical service agency providers, out-patient clinics)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or the agency must be contracted by the PIHP to provide family home care training services to SEDW consumers.

The agency must be certified by MDHHS as a PIHP or the agency must be contracted by the PIHP to provide family home care training services to SEDW consumers. The MDHHS/PIHP Managed Mental Health Supports and Services Contract specifies that the subcontract entered into by the PIHP shall address the following: a) Duty to treat and accept referrals; b) Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e) Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the PIHP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider is their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Service providers for Family Home Care Training must be clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Health and Human Services PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.
The service provider is selected on the basis of their 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 PIHP is the direct service provider. 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:

MDHHS verifies PIHP certifications on a triennial basis. The CMHSP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Support and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
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 is provided by a parent who has completed specialized training. It is a family-focused service provided to families (birth or adoptive parents,siblings, relatives, foster family, and other unpaid caregivers) of children serious emotional disturbance (SED) for the purpose of assisting the family in relating to and caring for a child with SED. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in his ability to achieve goals of: performing activities of daily living; improving functioning across life domain areas; perceiving, controlling, or communicating with the environment in which he lives; or improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

Coverage includes: Education and training, including instructions about treatment regimens to safely maintain the child at home as specified in the IPOS; peer support provided by a trained peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with a SED.

Parent-to-Parent Support is designed to support parents/family of children with SED as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals. This service will require a completion of a MDHHS approved Curriculum.

This service will not be duplicative of other services provided.

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

The frequency and duration of the training must be identified in the child's IPOS, along with the child's goal(s) that are being facilitated by this service.

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 agency contracted to the PIHP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Support and Training

Provider Category:

Agency

Provider Type:

PIHP or agency contracted to the PIHP

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

The PIHP agency must meet requirements as specified in Section 232a of the Michigan Mental Health Code, PA 258 of 1974, a amended, and the Administrative Rules applicable thereto.

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or the agency must be contracted by the PIHP to provide family support and training services to SEDW consumers. The MDHHS/PIHP Managed Mental Health Supports and Services Contract, specifies that the subcontract entered into by the PIHP shall address the following: a) Duty to treat and accept referrals; b) Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e) Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and
solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"
In addition, sub-contracts shall:
k) Require the provider to cooperate with the PIHP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

The Parent Support partner must complete the MDHHS statewide training Curriculum and be provided regular supervision and team consultation by the treating professionals.

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 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:

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Fiscal Intermediary

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio

Category 2: 12 Services Supporting Self-Direction

Sub-Category 2: 12020 information and assistance in support of self-direction

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 PIHP 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 consumer's 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/Self Determination arrangements. The "unit" for this billable code is "per month" and can be billed once per month for consumers using Choice Voucher/ Self Determination 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	Financial Intermediary Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Fiscal Intermediary

Provider Category:
Agency
Provider Type:

Financial 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 PIHP is responsible for verification of qualifications of agency providers with whom 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.

Frequency of Verification:

PIHPs verify that providers meet qualifications prior to delivery of services and at least annually 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, training, supervision and monitoring of Community Living Supports (CLS) staff by clinicians (i.e., licensed psychologist, Master's level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the consumer's POS, with focus on services designed to improve the child's/youth's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the consumer or others, or that cause property damage. The activities of the professional staff ensure the appropriateness of services delivered by CLS staff and continuity of care. This service can be provided by more than one clinician in any given month, as the service provider is selected on the basis of his/her competency in the aspect of the POS on which training is conducted.

Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50 through §440.60(a) and other applicable state and federal laws or regulations.

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

Up to 4 sessions per Calendar Month

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., clinical service agency providers, out-patient clinics)
Individual	Clinical professional as specified in other standard section and contracted by the PIHP.

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 PIHPs (e.g., clinical service agency providers, out-patient clinics)

Provider Qualifications

License *(specify)*:

The direct service 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)*:

NA

Other Standard *(specify)*:

The agency must be certified by MDHHS as a PIHP or the agency must be contracted by the PIHP to provide home care training, non-family services to SEDW consumers.

The MDHHS/PIHP Managed Mental Health Supports and Services Contract, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b) Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e) Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

The hands-on service provider must be a clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Community Health PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

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 PIHP is the direct service provider. 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:

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

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 as specified in other standard section and contracted by the PIHP.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

Service providers for Home Care Training, Non-Family must be clinical professional (Psychologist, Social Worker, Occupational Therapist, Physical Therapist, Speech Therapist, Music Therapist, Art Therapist, Therapeutic Recreation Specialist or Child Mental Health Professional). The Michigan Department of Health and Human Services PIHP/CMHSP Provider Qualifications defines a Child Mental Health Professional as an individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

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:

PIHPs are responsible for verifying contract service providers' qualifications.

Frequency of Verification:

Prior to delivery of service 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:

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 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.

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

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

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.

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 service provision with Overnight Health and Safety Support.

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 and other PIHP contracted providers
Individual	Aide

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Home care agency and other PIHP contracted providers

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or be contracted by the PIHP to provide CLS services to SEDW consumers.
The MDHHS/PIHP Managed Mental Health Supports and Services Contract, specifies that the subcontract entered into by the PIHP shall address the following: a) Duty to treat and accept referrals; b) Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and
solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the PIHP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Direct care, aide level staff employed by the PIHP must be a responsible adult at least 18 years of age and be; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and participant-specific emergency procedures, and report on activities performed, in good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony related to the kind of duty he/she would be performing, or not an illegal alien) able to perform basic
first aid procedures; and is trained in the individuals plan of service, 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 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:

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Aide

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

Individual is able to perform basic first aid procedures and is trained in the beneficiary's plan of service, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to delivery of services and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Therapeutic Activities

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
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 therapeutic activity is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the POS. The POS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the POS. Providers are identified through the wraparound planning process and participate in the development of a POS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include the following: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the POS. Services provided under Therapeutic Activities include music therapy, recreation therapy, and art therapy.

The training, coaching, supervision and monitoring activities provided under this service are specific to music, art and recreation therapy and must be provided by qualified providers of the therapies. This service is not duplicative of any other service provided.

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

This service may be billed for a maximum of 4 times 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
Agency	PIHPs or other agency on contract to the PIHP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Activities

Provider Category:

Agency

Provider Type:

PIHPs or other agency on contract to the PIHP

Provider Qualifications

License *(specify):*

NA

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 Board Certified (ATR-BC) Credentials Board, Inc. (ATCB)

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP or the agency must be contracted by the PIHP to provide Therapeutic Activities services to SEDW consumers.

The MDHHS/PIHP Managed Mental Health Supports and Services Contract, specifies that the subcontract entered into by the CMHSP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

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 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:

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Therapeutic Overnight Camp

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 group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Additional criteria:
Camps are licensed by the Department of Human Services (DHS);
The child's IPOS includes Therapeutic Overnight Camp; and
Camp staff is trained in working with children with SED.

Coverage includes:
Camp fees, including enrollment and other fees;
Transportation to and from the camp;
Additional costs for staff with specialized training with this population.

Coverage excludes:
Room and board for the camp.

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

Three sessions per year. Each session can encompass several days and nights.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Camps

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Overnight Camp

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications

License *(specify):*

Camps are licensed by the Department of Health and Human Services (DHHS)

Certificate *(specify):*

NA

Other Standard *(specify):*

The staff of the camp must be trained in working with children with serious emotional disturbance.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHPs

Frequency of Verification:

PIHPs verify that contracted agencies are licensed. The contract agencies verify that direct care staff 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:

Wraparound

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
01 Case Management	01010 case management
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):*

Wraparound services for children and adolescents is a highly individualized planning process facilitated by specialized supports coordinators. Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services, and other community services and supports. The Wraparound plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound.
Coverage includes:
Planning and/or facilitating planning using the Wraparound process, including at least one monthly face-to-face contact;
Developing an IPOS utilizing the Wraparound process;
Linking to, coordinating with, follow-up of, advocacy for, and/or monitoring of services with the Wraparound Community Team and other
community services and supports; Brokering with providers of services with the assistance of the Wraparound Community Team;
Assistance with access to other entitlements; and Coordination with the Medicaid Health Plan or other health care providers.

Coverage excludes:
Case management that is the responsibility of the child welfare, juvenile justice, or foster care systems;
Case management for legal or court-ordered non-medically necessary services;
Direct service provision; and Services and supports that are the responsibility of other agencies on the Community Team. All SEDW Wraparound enrolled providers must meet all of the requirements in the enrollment standards as listed in the Wraparound Services for Children and Adolescents subsection of the Mental Health/Substance Abuse chapter. In addition, due to the intense needs and level of risk of children/youth and their families served in the SEDW community-based waiver, all SEDW Wraparound providers must meet the following additional requirements:
Wraparound facilitators must possess a bachelor's degree and be a CMHP or be supervised by a CMHP.
Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS. This training is in addition to identified requirements for all supervisors and Wraparound facilitators.
Caseloads shall be 8-10 per facilitator based on needs and risks of the child/youth and family. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound. SEDW site reviews will assess fidelity to the model through case file review, quality assurance of all SEDW-provided services/supports, and interviews with children/youth and family members. All SEDW Wraparound enrolled providers must participate in the statewide evaluation project that consists of gathering data on the Family Status Report at intake, quarterly and at graduation. Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation. Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.

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

Billable Wraparound services include all collateral contacts and ancillary tasks/activities, as well as direct consumer contact - as described above. Contacts are based on need which is determined by the team; and only dates-of-
service for which there is a documented face-to-face encounter / event with the consumer can be billed. Therefore a "billable day" includes both direct consumer contact that occurred on the billed date-of-service, as well as all collateral/ancillary contacts that occurred on days on which there was not a face-to-face encounter with the consumer. During SEDW Site Reviews, documentation of all facets of Wraparound services is audited, including documentation of the face-to-face service provided on the date-of-service billed to Medicaid.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wraparound

Provider Category:

Agency

Provider Type:

PIHP or an agency contracted to the PIHP

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

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

The MDHHS/PIHP Managed Mental Health Supports and Services Contract, specifies that the subcontract entered into by the PIHP shall address the following: a) Duty to treat and accept referrals; b)Prior authorization requirements; c) Access standards and treatment time lines; d) Relationship with other providers; e)Reporting requirements and time frames; f) QA/QI systems; g) Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and
solvency requirements; h) Financing conditions consistent with this contract; I) Anti-delegation clause; j) Compliance with Office of Civil Right Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:
k) Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
l) Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
m) Require providers to meet accessibility standards as established in this contract.

Wraparound facilitators must:
1. Complete MDHHS wraparound training;
2. Possess a bachelor's degree in human services or a related field, or other Agency approved work/personal experience in providing direct services or linking of services for children with SED;
3. Have a criminal history screen, including state and local child protection agency registries; and
4. Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDHHS required training.

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 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:

MDHHS verifies PIHP certifications on a triennial basis. The PIHP verifies the qualifications of agencies on contract every two years.

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 are responsible for conducting case management (Wraparound Facilitator) functions and for the coordination of waiver services on behalf of waiver consumers.
Wraparound enrolled providers must meet all of the requirements in the enrollment standards as listed in the Wraparound Services for Children and Adolescents subsection of the Mental Health/Substance Abuse chapter in the MPM.. In addition, due to the intense needs and level of risk of children/youth and their families served in the SEDW community-based waiver, all SEDW Wraparound providers must meet the following additional requirements:
Wraparound facilitators must possess a bachelor's degree and be a (CMHP)or be supervised by a (CMHP). Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS. This training is in addition to identified requirements for all supervisors and Wraparound facilitators. Caseloads shall be 8-10 per facilitator based on needs and risks of the child/youth and family. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound. SEDW site reviews will assess fidelity to the model through case file review, quality assurance of all SEDW-provided services/supports, and interviews with children/youth and family members. All SEDW Wraparound enrolled providers must participate in the statewide evaluation project that consists of gathering data on the Family Status Report at intake, quarterly and at graduation. Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation. Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.

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) All direct care aide-level staff, all clinicians, and other CMHSP employees.
(b) The PIHP or it's contracted provider agency is responsible for completing the criminal history/background investigation by checking statewide databases and for providing documentation in the employee's personnel file. Michigan requires documentation of the Internet Criminal History Access Tool (ICHAT) which allows the search of public records contained in the Michigan Criminal History Record maintained by the Michigan State Police, Criminal Justice Information Center as evidence that a provider is in "good standing with the law". The QMP and SEDW site reviews are the mechanisms for ensuring the background checks are completed.
(c) requirements are set forth in the Michigan Medicaid Provider Manual, state that staff must 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, 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).**

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.*

Michigan does not allow payments to legal guardians or to relatives who are legally responsible for providing services to the child. Subject to this qualification 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.

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

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

○ **Other policy.**

Specify:

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

Any entity that meets certification requirements as specified in Section 232a of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto, can be certified by MDHHS as a Community Mental Health Service Program (CMHSP), and can enroll with Medicaid as a PIHP/CMHSP.

MDHHS contracts with PIHPs to carry out operational functions related to the SEDW, including directly providing at least one service and assuring a wide array of qualified service providers to provide a comprehensive array of services to meet the needs of children on the SEDW.

In order to provide an appropriate, adequate array of service providers, each PIHP/CMHSP establishes a procurement schedule/process for contracting with direct service providers. In addition, PIHPs/CMHSPs routinely expand their provider panel to meet the needs of SEDW consumers and upon request of consumers to add direct service providers.

The PIHP is the Provider of services. Individuals are given a choice of direct service providers that contract with the PIHP/CMHSP. If the family identifies a qualified provider, they refer that provider to the PIHP/CMHSP to become affiliated with the PIHP/CMHSP. Qualified providers chosen by the beneficiary should be placed on the provider panel.

Provider qualifications can be reviewed using the following links:

Medicaid Provider Manual (Children's Serious Emotional Disturbance Home and community-Based Waiver Appendix-B1)
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

The 1115 Pathways to Integration waiver operates concurrently with this §1915(c) waiver, effective 10/1/2019. This Managed Care Selective Contracting waiver formalizes MDHHS's relationship with PIHPs as the provider of services for all children enrolled in the SEDW.

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 SEDW services that meet initial credentialing standards prior to provider enrollment. Numerator: Number of applicants for provision of SEDW services that meet initial credentialing standards prior to provider enrollment. Denominator: All provider applicants for provision of SEDW 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: Proportinate random sample, 95% confidence level
	☒ **Other** Specify: biennial statewide dta 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 providers of SEDW services that continue to meet credentialing standards. Numerator: Number of providers of SEDW services that continue to meet credentialing standards. Denominator: All providers of SEDW 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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportinate 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: proportinate 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	

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:

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.

Section 6.4 of the contract between the MDHHS and the PIHPs/CMHSPs specifies provider network requirements. The PIHP is responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements to provide services.

The biennial QMP site reviews verify that the PIHP/CMHSPs have documentation of training required by policy, as published in the Michigan Medicaid Provider Manual. These reviews include discussions with PIHP/CMHSP staff, review of administrative policies and procedures, training, clinical record reviews, interviews with service recipients, and visits to some programs and residential sites.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 Site Review Team related to these assurances, an immediate review and response by the PIHP may be required. For all other identified individual issues, the PIHP is required to respond with a Remedial Action Plan/Plan of Correction within 30 days of receiving the formal report. Members of the Site Review Team review the Remedial Action Plans/Plans of Correction and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP and evidence submitted to MDHHS-BHDDA HSW 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 QMP Site Review Team members conduct a follow-up on-site visit approximately one year after the full site visit to assess the status and effectiveness of the PIHP's implementation of their submitted Remedial Action Plan/Plan of Correction. This visit also results in the issuing of formal correspondence to the PIHP.

When the Site Review Team notes issues related to provider qualifications related to the waiver, the team leader informs the SEDW Program Manager for follow-up, which may include providing training, consultation, or monitoring of PIHP follow-up.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

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 SEDW are living in their family home, in a foster family home or living independently and these settings are all in compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Plan of 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:

The Wraparound Facilitator, who leads the Child and Family Team in the development of the IPOS/Wraparound Plan of Care, must complete MDHHS required training. Also required is a bachelor's degree in human services or a related field; or other approved work/personal experience in providing direct services or linking of services for children with SED. Wraparound facilitators must have a criminal history screen, a screen with state and local Child Protection Agency registries. They must be supervised by an individual who meets criteria as a qualified mental health professional (QMHP), who has also completed MDHHS required training.

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:*

Michigan uses a Person-Centered Planning / Family Centered Practice approach that encompasses the belief that the family is at the center of the planning process and the service providers are collaborators. The family is the constant throughout the life of their children, while fluctuations occur at the service system level due to personnel changes and turnover. The wraparound process is an individualized, needs-driven, strengths-based process for children and families with multiple needs. The Child and Family Team include those persons most familiar with the child and family, plus service providers and community members. The majority of team members are the parents plus family members, friends and neighbors selected by the family. The functions of the Child and Family Team include: participating in the Strengths and Culture Discovery; developing a wraparound plan that is family-centered; developing crisis and safety plans; Works to support the implementation of the wraparound plan; accessing informal and formal supports/resources; Monitoring services/supports for effectiveness; evaluating on a regular basis the individual/family outcomes identified by the wraparound plan; pledging unconditional commitment; revising the wraparound plan based on changing needs, newly identified or developed strengths and/or on the result of an outcomes' review; and making provisions for long term support of the family after formal services are completed.
The core concepts of planning are the Strengths and Culture Discovery process, completed by the Child and Family Team, which identifies the assets of the family, assists the members of the Child and Family Team to obtain a balanced picture of the family and of other team members, and begins the joining process between the family and the team. The strengths and culture discovery process is built on the identified strengths and culture of the child and family. It is the role of the Wraparound Facilitator to ensure this is completed.
The Strengths and Culture Discovery process sets the stage for a holistic planning process and should: consider cultural differences in approaching families; identify the personal assets (values/attitudes, preferences, traditions/daily rituals, skills/abilities, interests, attributes/features) and resources of the individual, family and team member; and focus on the child, other family members and the family as a whole across all life domains.
Each Child and Family Team ensures that the plan is family-driven, not agency driven, and that it includes planning across all life domains, including; emotional/psychological/behavioral, health, education/vocational, financial/resources, cultural/spiritual, crisis, safety, housing/home, relationships/attachments, legal, daily living, family, social/recreational, and other life domains, as determined by the Child and Family Team. The Child and Family Team includes those persons most familiar with the child and family, plus service providers and community members. The Child and Family Team ensures that the plan is family-driven, not agency driven. The inclusion of these parties in the planning process helps to mitigate the service provider’s influence on the planning process. Additionally, the utilization review process, in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity, and effective use of resources, provides safeguards to mitigate the influence service providers on the planning process. 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. It includes a Crisis Plan that is intended to help prevent a crisis and to deal with the crisis when it occurs. The child, the family and/or the Child and Family Team define the "crisis". The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include a safety plan that is intended to insure the safety of the children or family members in the home.

The Child and Family Team develops a Plan of Service and a budget is completed that outlines use of community funds, family contributions, community donations and Medicaid funds. The Community Team approves all budget expenditures as recommended by the Child and Family Team.

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.

Michigan uses a Person-Centered Planning / Family Centered Practice approach that encompasses the belief that the family is at the center of the planning process and the service providers are collaborators. Wraparound is a mandatory service for all SEDW recipients. The Wraparound Facilitator orients that family to the SEDW including education regarding the SEDW, education regarding the Wraparound process, right to choose among qualified providers, right to choose among the various waiver services, information about the IPOS/Wraparound Plan developed through a person-centered process that is family-driven. The family is the constant throughout the life of their children, while fluctuations occur at the service system level due to personnel changes and turnover. The wraparound process is an individualized, needs-driven, strengths-based process for children and families with multiple needs and multiple system involvement. The Child and Family Team includes the family and those persons most familiar with the child and family selected by the family, plus service providers and community members. Team members are typically the parents, family members, friends and neighbors selected by the family. The functions of the Child and Family Team include: participating in the Strengths and Culture Discovery; needs assessment; developing a wraparound plan that is family-centered; developing crisis and safety plans; implementation of the wraparound plan; accessing informal and formal supports/resources; monitoring services/supports for effectiveness; evaluating individual/family outcomes identified by the family on a regular basis; pledging unconditional commitment to care; revising the wraparound plan based on changing needs, newly identified or developed strengths and/or on the result of an outcomes' review; and making provisions for long term support of the family after formal services are completed. The child and family decide individuals who are allowed to participate on the child and family team.

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):

Michigan uses a Person-Centered Planning / Family Centered Practice 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 children, while fluctuations occur at the service system level due to personnel changes and turnover. The wraparound process is an individualized, needs-driven, strengths-based process for children and families with multiple needs. The wraparound planning process begins prior to the application for the SEDW. Once needs are prioritized, the family is informed of available services and choice of qualified providers responsive to identified needs.
The Individual Plan of Service is a dynamic document that is revised based on changing needs, newly identified or developed strengths and/or the result of an outcomes' review update. The Child and Family Team include those persons most familiar with the child and family, plus service providers and community members. The majority of team members are the parents plus family members, friends and neighbors selected by the family. The functions of the Child and Family Team include: participating in the Strengths and Culture Discovery; developing a wraparound plan that is family-centered; developing crisis and safety plans; working to support the implementation of the wraparound plan; accessing informal and formal supports/resources; monitoring services/supports for effectiveness; evaluating on a regular basis the individual/family outcomes identified by the wraparound plan; pledging unconditional commitment; and making provisions for long term support of the family after formal services are completed. Wraparound team meetings are held at least weekly initially and subsequently no less than twice per month while enrolled in the SEDW unless otherwise documented in a transition plan. An essential component to engaging the family is the willingness to meet with the family wherever they want, and at a time that ensures their participation and the participation of those important to them. Two of the core concepts of planning are the Strengths and Culture Discovery and Life Domain Planning.
The Strengths and Culture Discovery process, completed by the Child and Family Team, identifies the assets of the family, assists the members of the Child and Family Team to obtain a balanced picture of the family and of other team members, and begins the joining process between the family and the team. The strengths and culture discovery process is built on the identified strengths and culture of the child and family. It is the role of the Wraparound Facilitator to ensure this is completed. The Strengths and Culture Discovery process sets the stage for a holistic planning process and should: consider cultural differences in approaching families; identify the personal assets (values/attitudes, preferences, traditions/daily rituals, skills/abilities, interests, attributes/features) and resources of the individual, family and team member; and focus on the child, other family members and the family as a whole across all life domains.

Each Child and Family Team ensures that the plan is family-driven, not agency driven, and that it includes planning across all life domains, including; emotional/ psychological/behavioral, health, education/vocational, financial/resources, cultural/spiritual, crisis, safety, housing/home, relationships/attachments, legal, daily living, family, social/recreational, and other life domains, as determined by the Child and Family Team. The Individual Plan of Service 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 condition requiring care.
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. Although a child or youth participates in planning for services, as minors, they cannot direct services or service providers. As noted above all individual plans of care include crisis and 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 and Family Team define the “crisis”. The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include 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 Child and Family Team develop a Plan of Service and provide on-going oversight, with the Wraparound facilitator taking the lead responsibility. The Child and Family Team must review the Plan of Service frequently, at least every 6 months but typically quarterly and revisions must be reflected in the Wraparound Plan/IPOS, and Child and Family Team minutes. The outcomes are reviewed, and progress measured by the Child and Family Team at least every 6 months but typically quarterly and changes are made if needed.
The Community Team formally reviews the Wraparound Plan/IPOS every six months. The supervisor will review the IPOS at least every three months; and the Child and Family Team, supervisor and the Community Team review crisis and safety plans. A budget is completed that outlines use of community funds, family contributions, community donations and Medicaid funds. The Community Team approves all budget expenditures as recommended by the Child and Family

Team. The Wraparound Plan/IPOS is signed by the parents, team members and Wraparound Facilitator at time of plan finalization and after each formal plan review.

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 IPOS' include crisis and 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 and Family Team define the "crisis".

The Crisis Plan should provide for around-the-clock response in the community (24 hours per day, 7 days per week) and include 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, is crisis 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.

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.

During the pre-planning meeting, families are informed that they can refer potential qualified providers to the PIHP/CMHSP to become a part of the PIHP/CMHSP provider network. Subsequent to the pre-planning meeting, once a child and family's needs are identified and prioritized a IPOS is created. The IPOS is grounded in the strength and culture discovery and is based on brainstorming options and strategies to meet the identified needs. Options and strategies include but are not limited to waiver services. Where waiver or state plan services are the appropriate service response, the Child and Family Team, led by the Wraparound Facilitator, continue to identify qualified providers from which the family may choose. The child and family choice drives the IPOS. This includes the child and family choice of qualified service providers from the PIHP/CMHSP provider network. The family choice of waiver services over institutional care is documented on the Waiver Certification form, "Parent Choice Assurance" section, and in minutes of Child and Family Team meetings, and the families signature on the IPOS.

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 MDHHS Division of Quality Management and Planning (QMP) site review team currently conduct biennial onsite visits to the PIHP/CMHSPs to ensure that plans of service for children on the SEDW meet the federal assurance and sub assurances related to participant centered planning and service delivery. The state chooses a representative sample of service plans to review with a 95% confidence interval. Because the SED waiver is a managed care program, day to day operations are performed by the approved PIHPs/CMHSPs.

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 maintains the records.

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.

Each child must have a Wraparound Facilitator who is responsible for monitoring the provision of services and supports, as identified in the Individual Plan of Service (IPOS) and crisis and safety plans. The Wraparound process requires a minimum of two in person meetings per month. The Wraparound Facilitator provides data (e.g. Child and Family Team minutes, data on goal achievement) to the Community Team to monitor outcomes of Plans of Service and expenditures. The Wraparound Supervisor is responsible for assuring that community safety is planned for and risk has been reduced. The Child and Family Team will review the IPOS at least monthly and revisions will be reflected in the IPOS, and Child and Family Team minutes. Child and Family Team minutes are part of the clinical records.
Participant access to non-waiver services identified in the IPOS, including health care, is part of the Life domainportion of the POS, and therefore monitored along with all other domains. Outcomes will be reviewed, and progress measured by the Child and Family Team at least monthly and changes will be made if needed. Parents are the essential component of the Child and Family Team, are integral to every decision, and must approve the IPOS priorto implementation or changes to the IPOS, as evidenced by their signature on the IPOS.
The Community Team formally reviews the IPOS at least every six months. The Wraparound Supervisor reviews the IPOS at least every three months. The Wraparound Facilitator, the Child and Family Team, Wraparound Supervisor, and the Community Team continually monitor participant health and welfare through their review of the crisis and safety plans.

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 Wraparound Facilitator provides direct services, the child and family team and the community team do not, and they ensure that monitoring is conducted in the best interest of the waiver participant.

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 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 Ongoing**	☒ **Other** Specify: Proportinate 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 has 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: Proportinate 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 of 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: Proportinate 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:

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: Proportinate 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**

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver 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 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: proportinate 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 are updated within 365 days of their last plan of service. Numerator: Number of enrolled consumers whose IPOS were updated wtihin 365 days of their last plan of services. 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: Proportinate random sample, 95% random sample
	☒ **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:

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: Proportinate 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**

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:

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/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers. Num: Number of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers. 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: Proportinate random sample, 95% confidence level
	☒ **Other** Specify: biennal 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 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** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportinate random sample, 95% confidence levle
	☒ **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 SEDW services and services in the State Psychiatric Hospital. Numerator: All parents or legal guardians of waiver consumer who are offered the choie between SEDW services and services in the State Psychiatric Hospital. Demoninator: 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**
☐ **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 Child and Family Team is charged with developing a IPOS for each child and family. The Wraparound Facilitator works with the team through the steps of the wraparound process to identify the child's and family's needs and create an action plan that is outcome driven. The team determines the type, amount, duration and frequency of services that will be provided, with the family having the lead voice on what makes sense to meet the outcomes. The Team also ensures that the IPOS incorporates strengths and is culturally relevant. The Child and Family Team review the IPOS at least monthly and changes are made as needed. Outcomes are reviewed and progress is measured by the Child and Family Team at least monthly. The Community Team also reviews and approves the plan initially and at least every six months and tracks service utilization.
The Wraparound supervisor reviews the IPOS at least every three months and the Community Team formally reviews the POS every six months. The Child and Family Team, supervisor and the Community Team also review the crisis and safety plans.
When the MDHHS SEDW site review team reviews a consumer record they look for the following things specific to the IPOS:
the individual 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 Wraparound principals; and services were delivered in accordance with 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.

Any findings noted during the site review process are included in a formal report issued by the MDHHS to the PIHP/CMHSP. The PIHP/CMHSP 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. A report of findings from the on-site reviews with scores is disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDHHS in 30 days. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Michigan has a long history of supporting opportunities for participant self-direction. In the early 1990's, as one of the eight Community Supported Living Arrangements (CSLA) states, Michigan collaborated with consumers of developmental disability services, their family members, advocates, providers, and other stakeholders to develop and operate a variety of Medicaid-funded services and supports pilots. These pilots were tightly governed under a values template of consumer choice and control. In 1995, when the Congressional "sun" set on the federal CLSA program, all of the CSLA consumers and as many of that program's self-directed features as the state was able to negotiate within its renewal were incorporated within this Waiver program. In 1996, the Michigan legislature made person centered planning a requirement for all participants receiving services and supports under the Mental Health Code.
Since 1997, when Michigan was awarded its Robert Wood Johnson Self-Determination demonstration grant, MDHHS has continued to build the demand and capacity for self directed services. Elements of participant direction are embedded in both policy and practice from Michigan's Mental Health Code, the Department's Person-Centered Policy Practice Guideline and Self-Determination Policy and Practice Guideline, the contract requirements in the contracts between the state and the PIHPs, and technical assistance at the state level for multiple methods for implementation by the PIHP. The Self-Determination Policy and Practice Guideline requires that PIHP/CMHSPs "assure that full and complete information about self-determination and the manner in which it may be accessed and applied is available to each consumer. This shall include specific examples of alternative ways that a consumer may use to control and direct an individual budget, and the obligations associated with doing this properly and
successfully." (I.C. page 4). Moreover, the policy states: "A CMHSP shall actively support and facilitate a consumer's application of the principles of self determination in the accomplishment of his/her plan of services." (I.E.. page 4).
(a) The nature of the opportunities afforded to consumers Adult SEDW consumers or their representative if minors 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 consumer's representative. Consumers can directly employ staff or contract with clinical providers through Choice Voucher/Self Determination arrangements. The responsible parent of the SEDW consumer represents the common law employer of the providers of hourly care staff (until age 18) and directs clinical 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 SEDW consumer directly recruits, hires and manages service providers. Detailed guidance to CMHSP entities on the Choice Voucher System is provided in the Choice Voucher System Technical Advisory.
(b) How consumers may take advantage of these opportunities Waiver participants have opportunities for both employer and budget authority. Participants may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. The participant may direct the budget and directly contract with chosen providers. The individual budget is transferred to a fiscal intermediary (this is Michigan's term for an agency that provides financial management services or FMS) which administers the funds and makes payment upon participant authorization. There are two options for participants choosing to directly employ workers: the Choice Voucher System and Agency with Choice. Through the first option, the Choice Voucher System, the participant is the common law employer and delegates performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Choice Voucher System Technical Advisory. In the Agency with Choice model, participants may contract with an agency with choice and split the employer duties with the agency. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Agency with Choice Technical Advisory.
A participant may select one or both options. For example, a participant may want to use the Choice Voucher System to directly employ a good friend to provide CLS during the week and Agency with Choice to provide CLS on the weekends. 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 about self-directed services is also provided by the Wraparound Facilitator (or other PIHP) to all SEDW-enrolled consumers and their families – at initial enrollment and on an on-going basis. The information is provided in the context of discussing options regarding waiver services and qualified providers. Parents of SEDW consumers interested in pursuing self-direction begin the process by letting their Wraparound Facilitator (or other PIHP) 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, Wraparound Facilitator, 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 SEDW 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 participant direction. Each PIHP also offers support to consumers and their families who choose self-direction. 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.

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 Self Directed service or Choice Voucher arrangements, the following two waiver services are considered provider managed services only:

1. Environmental accessibility adaptations/specialized medical equipment/supplies.
2. financial managementservices.

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 self-directed services through 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, the wraparound facilitator will assist in gaining an understanding about the Choice Voucher System, and how those options might work for the consumer.
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)/ Wraparound Plan through the person-centered planning (PCP) process. 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 Self Determination 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 consumer’s 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. Children living in the community with parents or legal guardians served by the SEDW are to be provided with information about the Choice Voucher System/Self Determination Arrangements. 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.
Self-Directed/Choice Voucher enrollment begins 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 SEDW 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
Respite	☒	☒
Therapeutic Activities	☐	☒
Family Home Care Training	☐	☒
Community Living Supports	☒	☒
Overnight Health and Safety Support	☒	☒
Fiscal Intermediary	☐	☒
Home Care Training, Non-Family	☐	☒
Family Support and Training	☐	☒

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/participant'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 haveresponsibility 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 CMHSP 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 CMHSP.

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 Quality Management Program (QMP) 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)*:

- [x] **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 child's 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 an 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 SEDW 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 case manager 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
Respite	☐
Therapeutic Activities	☐
Family Home Care Training	☐
Therapeutic Overnight Camp	☐
Community Living Supports	☐
Overnight Health and Safety Support	☐
Fiscal Intermediary	☒
Home Care Training, Non-Family	☐
Family Support and Training	☐
Wraparound	☐
Child Therapeutic Foster Care	☐

☐ **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/or 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. Authorization of the IPOS and individual budget cannot be delegated to an individual advocate by the PIHP.
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.

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.
The Self-Determination Policy and Practice Guideline sets forth the procedure for the PIHP to follow. The Self Determination Agreement defines the responsibilities of the parties regarding participation 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 child’s right to access services through the PIHP. 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 or CMHSP may involuntarily terminate participant direction when the health and welfare of the participant is in jeopardy or other serious problems are resulting from the participant's failure in directing services and supports or when the consumer's representative consistently fails to comply with contractual requirements. The Self-Determination Policy and Practice Guideline sets forth the procedure for the PIHP to follow, and provides direction as follows: "Prior to the [PIHP] terminating an agreement, and unless it is not feasible, the PIHP shall inform the participant of the issues that have led to the decision to consider altering or discontinuing the arrangement in writing, and provide an opportunity for problem resolution. Typically, the person-centered planning process will be used to address the issues, with termination being the option of choice if other mutually agreeable solutions cannot be found". In any instance of discontinuation or alteration of a self-determination arrangement, the local grievance procedure process may be used to address and resolve the issues. The decision of the PIHP to terminate participant direction does not alter the services and supports identified in the individual plan of service. In that event, the PIHP has an obligation to take over responsibility for providing those services through its network of qualified providers.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		19
Year 2		38
Year 3		57
Year 4		76
Year 5		96

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:

☒ **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:

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.

The IPOS identifies the amount, scope and duration of services for which the consumer can exercise budget authority. The Medicaid fee screens establish the limit for each service and the consumer can determine the amount paid for services within the established limit. The amount of service to be provided can be revised as needed up to the maximum established by the program and as approved in the IPOS.

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.

The budget, which reflects the services identifed in the IPOS, and includes but is not limited to the self-directed services, is provided to the family annually. The budget is merely a reflection of the services identified in the IPOS. If the IPOS does not adequately address the consumers needs, they can request a revision in the IPOS and can request a Fair Hearing when a services is denied or reduced.

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:

The IPOS identifies all services needed by the consumer and the budget merely reflects the services as identified in the IPOS, including the self-directed and other services. Consumers can request changes in the IPOS as needed to meet their needs. Payment for services can not exceed fee screens for the services and the amount, scope and duration of services can not exceed state maximums for the service. The FI reports service utilization to the CMHSP on a monthly basis and the case manager and CMHSP monitor utilization to assure all service needs as identified in the IPOS are met.

CHAMPS, the automated invoice system, has frequency and quantity parameters built into their edits, so if a service is over utilized, it is not paid.

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 represents themselves for intake at a PIHP/CMHSP they are provided basic information regarding available services, recipient rights, local dispute resolution and administrative hearings. At the time of POS development, the consumer is again notified of these rights.

The MDHHS Administrative Tribunal provides a hearing to appellants requesting a hearing who do not agree with a decision made by MDHHS or PIHP/CMHSP. 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 may include a termination, suspension or reduction of Medicaid eligibility or covered services. 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 a Plan of Service; 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 action is pended to provide the parent or guardian an opportunity to react to the proposed action. 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 ALJ or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing.

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 State Office of Administrative Hearings and Rules must receive the written hearing request within that 90-day period. If a Medicaid covered service is being reduced, suspended or terminated, a written notice must be mailed to the child or authorized representative at least 12 days before the intended action When an individual represents themselves for intake at a PIHP/CMHSP they are provided basic information regarding available services, recipient rights, local dispute resolution and administrative hearings. At the time of POS development, the consumer is again notified of these rights. The MDHHS Administrative Tribunal provides a hearing to appellants requesting a hearing who do not agree with a decision made by MDHHS or PIHP/CMHSP. 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 may include a termination, suspension or reduction of Medicaid eligibility or covered services. 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 a Plan of Service; 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 action is pended to provide the parent or guardian an opportunity to react to the proposed action. 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 ALJ or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing.

The Request for Hearing form (DCH-0092) or its equivalent is sent to the parent or guardian with all adequate or advance notices. It is the responsibility of the CMHSP 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/CMHSP at a hearing.

If a parent or guardian wants to appeal an action, the request for a hearing must be in writing and sent to the State Office of Administrative Hearings and Rules (often referred to as the Administrative Tribunal). 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 State Office of Administrative Hearings and Rules must receive the written hearing request within that 90-day period. If a Medicaid covered service is being reduced, suspended or terminated, a written notice must be mailed to the child or authorized representative at least 12 days before the intended action takes effect. The letter sent to the parent/guardian also indicates that 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 ALJ, or the parent or guardian withdraws the request for hearing, or the parent or guardian does not appear at a scheduled hearing.

Upon receipt of a hearing request, the State Office of Administrative Hearings and Rules assigns a docket number and faxes a

copy of the Request for Hearing to the CMHSP that took the action being appealed. The hearings coordinator is responsible for receiving hearing requests, identifying the responsible staff and forwarding a completed Hearing Summary to the State Office of Administrative Hearings and Rules and the appellant within 14 days of receipt of the hearing request, but no later than seven (7) days prior to a scheduled hearing date.

The PIHP/CMHSP staff prepares the DCH-0367 Hearing Summary form and presents the case at the hearing. The Hearing Summary must be completed in its entirety. The narrative must include all of the following: A clear statement of the action or decision being appealed, including all programs involved in the action; Facts which led to the action or decision; Policy which supported the action or decision; Correct address of the appellant or authorized hearing representative; Copy of the documents the PIHP/CMHSP intends to offer as exhibits at the hearing; Appellants and authorized hearing representatives (AHR) have the right to review the case record and obtain copies of all documents and materials to be used or relied upon at the hearing. (A copy of the hearing summary, and all supporting documents to be used at the hearing, is sent to the appellant and AHR. All parties should receive copies of the Hearing Summary and all documents at least seven days before the scheduled hearing.) A copy of the documents is also sent to the Children's Home and Community Based Waiver Director.

The ALJ conducts the hearing from his/her office. The appellant or AHR is directed to the local PIHP/CMHSP or other location as indicated on the notice. The appellant or AHR may request permission of the Administrative Tribunal to appear by phone from an alternative location. The request must be made to the State Office of Administrative Hearings and Rules at least one full business day before the hearing. The appellant or AHR may request the ALJ appear in person at the hearing. The ALJ will travel to the local office or facility. The parties present their positions to the ALJ who determines whether the actions taken are correct according to fact, law, policy and procedure. The Hearing Summary, or highlights of it, may be read into the record. The Hearing Summary may be used as a guide in presenting evidence. Both parties must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses and cross-examine the author of a document offered in evidence. The ALJ must ensure the record is complete and may take an active role in the questioning of witnesses and parties. The ALJ will assist either side to ensure all necessary information is presented on the record or refuse to accept evidence the ALJ believes is unduly repetitious, immaterial, irrelevant or incompetent. Either party may state on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement and object to evidence the party believes should not be part of the hearing record. When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and the reason it was not admitted. The ALJ may allow written documents to be admitted in place of oral
testimony if the ALJ decides this is fair to both sides.

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 State Office of Administrative Hearings and Rules. A copy of the withdrawal is maintained in the child's record.

The ALJ's Decision and Order is the final determination of MDHHS. Rehearing or reconsiderations may be requested within 30 days of the Decision and Order. All documentation is maintained in the waiver participant'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.

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.

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).

Michigan's critical incident management system is a statewide system encompassing everyone who receives public mental health services. The local Community Mental Health Services Program (CMHSP) is responsible for some functions of the critical incident management system, while the Prepaid Inpatient Health Plans (PIHPs) are responsible for others. Where the function is performed by the PIHP, the link between the CMHSP and the PIHP will be described.

MDHHS-BHDDA requires the PIHP/CMHSPs to report critical incident data and related information as measures of how well the PIHP/CMHSP and its contracted providers monitor the care of vulnerable service recipients, including SEDW consumers. The MDHHS-BHDDA requires reporting on the following critical events: abuse, exploitation or neglect that results in emergency medical treatment or hospitalization, suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error and arrest of consumer. Allegations of abuse, exploitation and neglect are also reported to the local CMHSP Office of RecipientRights (ORR). Definitions follow after the description of the system for reporting.
Three reporting processes, each with a purpose and intended outcome, comprise the backbone of Michigan's system for assuring participant safeguards. The reporting processes are: Event Notification (EN), Sentinel Event (SE) Root Cause Analysis and Findings, and the Critical Incident Reporting System (CIRS). When an event occurs, the first step is that staff generates an Incident Report. Depending on the event, it may be subject to the requirements of one or more of the reporting processes. As an example, if a child on the SEDW were to die, section 6.1.1 (EN) of the MDHHS/PIHP contract requires the PIHP to report to the State immediately any death that "occurs as a result of suspected staff member action or inaction, or any death that is the subject of recipient rights, licensing, or police investigation." This report must be "submitted electronically within 48 hours of the death, or the PIHP/CMHSP's receipt of notification that a rights, licensing, and/or police investigation has commenced." The purpose and outcome of immediate reporting is to assure health and welfare of any other recipients and coordination of investigations resulting from the incident. If the death is considered "unexpected", the contract requires that the PIHP/CMHSP commence a SE root-cause analysis within 48 hours. "Unexpected deaths" are defined as "those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect." The
purpose of this process is to identify the root cause(s) and identify strategies for quality improvement and prevention of future incidents. This process is completed at the local PIHP/CMHSP level and is available for review by the EQR and the State during site reviews. The third process requires reporting of all deaths, including those of recipients of SEDW services, via the CIRS - regardless of whether that death also required immediate reporting under the EN requirement and/or SE root-cause analysis and findings. The purpose of this requirement is to complete state-level analysis with outcomes to improve quality throughout the system, as well as to address individual-specific issues identified by the CIRS. In addition to the above, PIHP/CMHSP program staff would alert MDHHS through the Waiver Support Application, indicating the child's case is closed and the reason for the closure.

EVENT NOTIFICATION (EN): Section 6.1.1 of the contract between MDHHS and PIHP requires that the PIHP "immediately notify MDHHS" of any of the following egregious events: any death that occurs as a result of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation; relocation of a consumer's placement due to licensing issues; an occurrence that requires the relocation of a PIHP/CMHSP or provider panel service site, governance, or administrative operation for more than 24 hours; and conviction of a PIHP/CMHSP or provider panel staff member for any offense related to performance of their job duties or responsibilities. Deaths must be reported electronically within 48 hours of either the death or the PIHP's/CMHSP's receipt of notification that a rights, licensing, and/or policy investigation has begun. Notification of the other events must be made telephonically or via other forms of communication to MDHHS's contract management staff within five business days.

The PIHP/CMHSP is responsible to assure the immediate health and welfare of all SEDW consumers, as well as that of any other mental health recipients who could be at risk as a result of the reported incident. All other qualified Medicaid enrolled providers providing services to SEDW consumers are responsible to assure the health and welfare of the children they serve. If an event is reported for a child on the SEDW, waiver program staff follow-up with the PIHP/CMHSP within 1 business day of the report to assure the health and welfare of the child. The PIHP/CMHSP is required to submit a plan of correction that identifies systems changes in place that will prevent reoccurrence of such an event. Depending on the event, MDHHS staff may make a site visit to the PIHP/CMHSP to follow up on the implementation of the plan of correction.

CRITICAL INCIDENT REPORTING SYSTEM (CIRS): The CIRS enables MDHHS to receive data on individual consumers within specified timeframes, depending on the type of event. Children enrolled in the SEDW are a reportable population in the CIRS. All providers of waiver services must report incidents, such as an injury or the use of physical

management permitted for intervention in an emergency, on an incident report form that is submitted to the PIHP/CMHSP. For any of the required events, the CMHSP must submit data to the PIHP to report 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. Program staff follow-up on incidentsreported in the CIRS, and a plan of correction may be required by the PIHP/CMHSP depending on the incident. Onsite follow up may also occur during biennial site reviews. The data from the CIRS is used for federal reporting
purposes, to identify potential trends and to determine the type of technical assistance, consultation, or training that needs to be provided to the PIHPs/CMHSPs. The PIHP/CMHSP is responsible to assure the immediate health and welfare of the SEDW
participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident. Providers on contract with the CMHSPs must report Critical Incidents in a manner that allows the PIHP to report incidents to the MDHHS within the timeframes listed below. Timeframes for reporting the five specified events in the CIRS 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 CIRS, a consumer's death shall be reported as a suicide when either one of the following two conditions exists, the PIHP/CMHSP serving the consumer determines, through its death review process, that the consumer's death was a suicide, or the official death report (i.e., coroner's report) indicates that the consumer's death was a suicide. If 90 calendar days has elapsed without a determination of cause of death, the PIHP/CMHSP must submit a "best judgment" determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
Non-suicide Death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the PIHP/CMHSP attempts to determine whether the death was due to suicide. In that case the submission is due within 30 days of the end of the month in which CMHSP determined the death was not due to suicide.
Emergency Medical Treatment Due to Injury or Medication Error: Due within 60 days after the end of the month in which the emergency medical treatment began.
Hospitalization Due to Injury or Medication Error: Due within 60 days after the end of the month in which the hospitalization began.
Arrest: Due within 60 days after the end of the month in which the arrest occurred.
SENTINEL EVENT (SE): Any provider of waiver services report incidents, such as an injury or the use of physical management permitted for intervention in an emergency, on an incident report form that is submitted to the PIHP/CMHSP. The PIHP/CMHSP must review the incident to determine if it meets the criteria and definitions for SE and is related to practice of care as described in G-1-d. If the incident if a SE, the PIHP/CMHSP must undertake a process that begins with a root cause analysis and ends with quality improvement activities. Depending on the type of incident, it may also be required to be reported on the CIRS through the PIHP to MDHHS. The local CMHSP ORR would also receive a copy of the incident report and may also investigate as described in the CMHSP ORR section in G-1-d. If the CMHSP ORR substantiates a rights violation related to abuse, including exploitation, or neglect, the ORR makes recommendations for remediation to the PIHP/CMHSP director. Appropriate remedial action must be taken and documented when there is a substantiated recipient rights violation per the MDHHS/PIHP Contract, Attachment C6.8.1.1. The PIHP/CMHSP is responsible to assure the immediate health and welfare of the SEDW participant, as well as that of any other mental health recipients who could also be at risk as a result of the reported incident.

OFFICE OF RECIPIENT RIGHTS: Allegations of abuse (including exploitation) and neglect are reported to the local CMHSP ORR through the incident report forms and/or recipient rights complaint forms. Any person employed by the MDHHS, each PIHP/CMHSP, each licensed hospital, and each service provider under contract with the MDHHS has a duty to report any suspected abuse and/or neglect to the local ORR. Michigan law and rules require the mandatory reporting of recipient rights complaints in a timely manner to the CMHSP ORR. PIHP/CMHSP policies further specify that reports of rights violations are immediately reported to their ORR. Reporting may be done in writing or by phone or by other means of communication, such as fax. If the ORR substantiates a rights violation related to abuse, including exploitation or neglect, the ORR makes a recommendation for remediation to the PIHP/CMHSP director. Appropriate remedial action must be taken and documented when there is a substantiated recipient rights violation per the MDHHS-PIHP/CMHSP contract. Certain situations involving suspected abuse and neglect must also be reported to law enforcement or CPS. The Michigan Mental Health Code requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: [the reporter] "immediately shall make or cause to be made, by telephone or otherwise, anoral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police. Within 72 hours after making the oral report, the

reporting individual shall file a written report with the law enforcement agency to which the oral report was made and with the chief administrator of the facility or agency responsible for the recipient (330.1723)."
Michigan's Child Protection Law requires the following with regard to reporting suspected child abuse or neglect to DHHS CPS for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: [the reporter] "immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this Act (722.623)."

OTHERS: Other agencies, such as law enforcement, protective services, or licensing, may receive reports of allegations of abuse, neglect, and exploitation. Where SEDW consumers receive waiver services in licensed settings (e.g., respite care in licensed camps and foster family settings), Michigan law and rules require the licensee to complete an Incident/Accident Report (a copy of which is forwarded to the PIHP/CMHSP ORR) and to make a reasonable attempt to contact the child's parent/legal guardian and responsible agency by telephone and follow the attempt with a written report to the designated representative, responsible agency and the children's foster care licensing division within 48 hours. The incident/accident report from the licensee is provided to the PIHP/CMHSP, the responsible agency, which would assure the immediate health and welfare of the consumer, as well as that of any other mental health recipients in the home. A licensee is required to report any of the following:
R 400.9413 Unusual incident notification.
Rule 413.
(1) A foster parent shall immediately notify the agency of the death of a foster child.
(2) A foster parent shall immediately notify the agency of the removal or attempted removal of a foster child from a foster
home by any person not authorized by the agency.
(3) A foster parent shall notify the agency within 24 hours of determining that a foster child is missing.
(4) A foster parent shall notify the agency within 24 hours after the foster parent knows of any of the following:
(a) Any illness that results in inpatient hospitalization of a foster child.
(b) Any accident or injury of a foster child that requires medical treatment by a licensed or registered health care person.
(c) A foster child's involvement with law enforcement authorities.

Members of the general public may also make reports of incidents of alleged abuse, neglect, exploitation or other concerns. Contact information for local community mental health services programs is available on each CMHSP's website and phone numbers are listed in the phone book. Contact information for the local offices of recipient rights is located on the state ORR's web page and has been modified to make the information easier to access related to how and where to report concerns of suspected abuse, neglect or exploitation. The SEDW web page contains a link to the State's ORR web page.

DEFINITIONS:
Definitions of Abuse and Neglect (MDHHS Administrative Rule 330.7001):
Abuse is divided into three categories, Abuse Class I, Abuse Class II and Abuse Class III. Neglect is also divided into three categories, Neglect Class I and Neglect Class II and Neglect Class III. Abuse Class I and II and Neglect Class I and II are required to be reported to MDHHS on a semi-annual basis as each involves some level of physical or emotional harm to the recipient or involves sexual abuse.

Abuse Class I means a non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient.

Serious Physical Harm means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Sexual Abuse means any of the following:
(i) Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an
employee, volunteer, or agent of a provider and a recipient.
(ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or
center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a

recipient.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.

Sexual Contact means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:
(i) Revenge.
(ii) To inflict humiliation.
(iii) Out of anger.

Sexual Penetration means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Abuse Class II means any of the following:
(i) A non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to nonserious physical harm to a recipient.
(ii) The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm.
(iii) Any action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a recipient.
(iv) An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.
(v) Exploitation of a recipient by an employee, volunteer, or agent of a provider.

Emotional Harm means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Exploitation means an action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Non-serious Physical Harm means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.
Neglect Class I means either of the following:
(i) Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient.
(ii) The failure to report apparent or suspected abuse Class I or neglect Class I of a recipient.

Definitions for Sentinel Events (SE):
Sentinel Event: An “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (JCAHO, 1998) [excerpt from MDHHS-BHDDA Guidance on entire Reporting (PIHPs)].
Incident: any of the following which should be reviewed to determine whether it meets the criteria for SE:
- death of recipient - that which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
- serious illness requiring admission to hospital – does not include planned surgeries, whether inpatient or outpatient, or

admissions directly related to the natural course of the person's chronic illness or underlying condition.
- alleged case of abuse or neglect
- injury from accident or abuse to the recipient requiring emergency room visit or admission to hospital
- serious challenging behavior - those not already addressed in a treatment plan and include significant (in excess of $100)
property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence. Serious physical harm
is defined by the Administrative Rules for Mental Health (300.7001) as “physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his
or her bodily functions, or caused the permanent disfigurement of a recipient.”
- arrest and/or conviction - any arrest or conviction that occurs with an individual who is in the reportable population at the time the arrest or conviction takes place.
- medication error a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage that resulted in death or serious injury or the risk thereof. It does not include instances in which consumers refused medication.

Definitions for Critical Incident Reporting System (CIRS):
Suicide - a Consumer’s death shall be reported as a suicide when either one of the following two conditions exists:
a. The CMHSP serving the consumer determines, through its death review process, that the consumer’s death was a suicide, or
b. The official death report (i.e., coroner’s report) indicates that the consumer’s death was a suicide.

Non-suicide Death - any death, for consumers in the reportable population, that was not otherwise reported as a suicide.
Emergency Medical Treatment Due to Injury or Medication Error - Situations where an injury to a consumer or a medication error results in face-to-face emergency treatment being provided by medical staff. Any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms should be reported, provided the treatment was sought due to an injury or medication error.

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

Injury - bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body. Examples of injuries include bruises (except those due to illness), contusions, muscle sprains, and broken bones.
Hospitalization Due to Injury or Medication Error - Admission to a general medical facility due to Injury or Medication Error. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

Arrest - Situations where a consumer is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a consumer is transported for the purpose of receiving emergency mental health services, or situations where a consumer is held in protective custody, are not considered to be an arrest.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDHHS entitled “YOUR RIGHTS When Receiving Mental Health Services in Michigan” at the time of admission into services and periodically thereafter. The SEDW consumer's Wraparound Facilitator or other QMHP provides information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of SEDW 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 for review by applicants and recipients." From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the 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 CMHSP, 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 CMHSP ORR if the recipient, legal representative, or anyone on behalf of the recipient feels that the recipient’s rights have been violated, including the right to be free from abuse or neglect.

Section 6.3.1 of the MDHHS-BHDDA-PIHP/CMHSP contract requires that each PIHP/CMHSP must provide customer services and there is an assigned customer services coordinator for each PIHP/CMHSP that oversees customer services at the PIHP/CMHSP. In addition, each CMHSP 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 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/CMHSPs and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients’ rights. CMHSP ORRs conduct rights informational sessions for consumers, family members, advocates and interested others. Additionally, the MDHHS holds annual Recipient Rights, Consumer, Wraparound 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 compliant 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.

EVENT NOTIFICATION: Per section 6.1.1 of the MDHHS-BHDDA/CMHSP contract, the CMHSP must immediately report certain events to MDHHS, as described in Section G-1-b, and as required by Attachment P6.7.1.1 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 occurs as a result of suspected staff member action or inaction. The written report will include consumer information, date, time and place of death (if in a foster care setting, the foster care license #), final determination of cause of death (from coroner's report or autopsy), summary of conditions (physical, emotional) and treatment or interventions preceding death, any quality improvement actions taken as a result of an unexpected or preventable death, and the PIHP/CMHSP's plan for monitoring to assure any quality improvement actions are implemented.
Immediate event reporting is considered an egregious situation and is reviewed through the MDHHS internal process.

SENTINEL EVENT: The CMHSP must review the incident to determine if it meets the criteria and definitions for sentinel events and is related to practice of care. Depending on the type of incident, it may also be required to report on the Critical Incident Reporting System through the PIHP to MDHHS. In the MDHHS-BHDDA/CMHSP contract, Attachment C 6.8.1.1 requires that each CMHSP must have a Quality Improvement Program (QIP). The QIP describes, and the CMHSP implements, the process of the review and follow-up of sentinel events. The CMHSP has two business days after a critical incident occurred to determine if it is a sentinel event and commence the root-cause analysis. The outcome of this review is a classification of incidents as either sentinel events or non-sentinel events.

Sentinel events include: death of the recipient, any accident or physical illness that requires hospitalization, incidents that involve arrest or conviction of the recipient, emergency physical management interventions used for controlling serious challenging behaviors and medication errors (definitions in G-1-b). Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, including all SEDW consumers (deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), who at the time of their deaths were receiving waiver services, must be reviewed and must include:
- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.
The use of physical management, permitted for intervention in emergencies only, is considered a critical incident that must be managed and reported through the PIHP according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined in the MDHHS/CMHSP contract attachment C6.8.3.1 as "a technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan." Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The MDHHS requires CMHSPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the CMHSP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. [excerpt from MDHHS Guidance on Sentinel Event Reporting] 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 CIRS would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse, including exploitation or neglect. Additionally, some of the incidents reported in the CIRS, such as a death or injury, could result in a criminal investigation or referral to Child Protective Services (CPS). All events are included in aggregate trend and analysis reports. Events that are considered priorities, such as certain types of deaths (suicide and accidental deaths for

example) and injuries (related to the use of restrictive interventions or medication errors for example), are reviewed through the MDHHS internal process. During biennial on-site reviews, MDHHS-BHDDA verifies the process for Critical Incident Reporting is being implemented per MDHHS policy. If it is not, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP (including CMHSP affiliates as applicable. Section G-1-b of this application defines incidents and identifies time lines for reporting to the state.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the ORR shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the consumer within five days acknowledging receipt of the complaint and then provides written updates every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report of the investigation including the conclusion by the ORR and the action or plan of action to remedy a violation to the complainant,
recipient if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights.

Information gathered from investigations is reviewed for trends and becomes a focus of the state ORR visits to CMHSPs. Aggregate data are shared with MDHHS Behavioral Health and Developmental Disabilities 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, DHHS-CPS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring consumer safety. The CMHSP ORR is responsible for investigating rights violations. The DHHS Licensing and Regulator 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. Local DHHS offices must have signed agreements with their respective CMH boards to cover roles and responsibilities for handling APS investigations in mental health settings. The protocol for joint operating agreements and the model agreements for this coordination for reporting, investigating and sharing information are in the Adult Services Manual (DHS-ASM 256). If, during an MDHHS on-site visit, the site review team member identified an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

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

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

CRITICAL INCIDENT REPORTING SYSTEM: The CIRS enable MDHHS to better monitor the types of events which occur populations, such as the ability to monitor incidents for SEDW consumers. Since individual consumer identification is 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/CMHSP responsibility for critical incident management for the SED waiver population by measuring the rate of critical incidents for SEDW consumers. After establishing a baseline "occurrence" rate, 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 incidents 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/CMHSP when concerns arise regarding SEDW consumers. Technical assistance, consultation, and referrals for additional follow-up or training are provided as required. On-site follow-up may be provided by site review or waiver staff on reported incidents. More frequent reviews by MDHHS staff may be required in addition to site reviews, depending on the situation. During site reviews, MDHHS staff examine the critical incident reporting process, as well as the success of actions taken to prevent or reduce the likelihood that a type or class of reportable event would re-occur. Any noted shortcomings in the processes or outcomes would be reflected in the CMHSP's written site review report which would in turn require submission of a corrective action plan within 30 days. The corrective action plan is reviewed by 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. This state oversight by the QMP assures the necessary processes are in place for participant safeguards.

As part of Michigan's overall quality oversight of public mental health services, including the SEDW, the External Quality Reviews examine the performance indicator for sentinel event reporting to assure that the QAPIP at each PIHP (and affiliate CMHSPs as applicable) describes the process for review and follow-up of sentinel events. Because of the nature of sentinel event reporting, a score is given to validate that the processes are in place for review and follow-up. This report indicates that the processes are in place for all recipients of mental health services, including SEDW consumers. 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 CMHSP 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 CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semiannual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population, including SEDW consumers. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this

oversight is conducted and its frequency:

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 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; the Agreement Between MDHHS-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Michigan Department of Health and Human Services Bureau 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 DHS-BCAL during announced or unannounced inspections and at the time of the biennial licensure process.
Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per 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 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.

The MDHHS contract with the PIHPs and CMHSPs includes Attachment P 1.4.1 Technical Requirement for Behavior Treatment Plan Review Committees, which addresses the use of restraint, seclusion, and restrictive interventions.

It is the policy of MDHHS that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" or "Committee". The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards contained in the Attachment P 1.4.1. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions The Committee shall be comprised of at least three individuals, one of whom shall be a licensed psychologist as defined in the Staff Provider Qualifications, in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, with the specified training and experience in applied behavior analysis; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non voting members may be added at the Committee's discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision making.

The functions of the Committee shall be to:
1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.

Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of

aversive techniques is prohibited.

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

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual’s rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

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

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

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

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

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

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

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

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

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

The PIHP/CMHSP Behavior Treatment Plan Review Committee must, on a quarterly basis, track and analyze the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
1. Dates and numbers of interventions used.
2. The settings (e.g., group home, day program) where behaviors and interventions occurred
3. Behaviors that initiated the techniques.
4. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
5. Attempts to use positive behavioral supports.
6. Behaviors that resulted in termination of the interventions.
7. Length of time of each intervention.
8. Staff development and training and supervisory guidance to reduce the use of these interventions.

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

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

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

MDHHS-BHDDA oversees the activities of the PIHP (or CMHSP as applicable) Behavior Treatment Plan Review Committees through quarterly reporting from Committees to MDHHS for SEDW consumers whose plans include the use of intrusive or restrictive techniques and biennial Site Reviews. If issues or critical incidents related to the use of restrictive interventions is noted, MDHHS-BHDDA may require the PIHP and CMHSP staff to receive training in the culture of gentleness and positive behavioral supports, as well as recommend other approaches or strategies as appropriate.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHPs/CMHSPs Quality Improvement Program and be available for MDHHS review.

Appendix G: Participant Safeguards

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

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

○ **The state does not permit or prohibits the use of seclusion**

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix

does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

Most SEDW consumers live with family and medication management and administration are the family's responsibility. In those instances where the consumer and family use licensed settings, the CMHSPs have ongoing responsibility for "second line" management and monitoring of consumer medication regimens. "First line" management and monitoring is the responsibility of the prescribing medical professional. The consumer's IPOS must contain complete information about their 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 Child and Family Team [as authorized by the consumer and his/her parent], and all provider staff with medication administration/self-administration assistance/ monitoring responsibilities. This helps all within the consumer's planning/service/support network to know when to request a formal medication review outside those scheduled within the plan.

The PIHP/CMHSP medications monitoring procedure, called a medication review, is by definition the evaluation and monitoring of medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications. The frequency of regular medication reviews must be specified in the 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/CMHSP medical professionals specified in the plan, home based clinicians and others are trained to spot signs and symptoms of potentially harmful practices. Any of these staff can request an unscheduled medication review and a planning meeting to address any confirmed issues. Also, during Wraparound meetings with the Child and Family Team, if a concern about the child's medications is raised at a Wraparound meeting, the Wraparound Facilitator would ensure that a medication review is scheduled.

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

Any use of behavior modifying medications is an intrusive technique as defined in the Agreement between MDHHS-BHDDA and PIHPs For Managed Mental Health Supports and Services 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 SEDW 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 Critical Incident Reporting System and conduct a sentinel event investigation.

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

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

○ **Not applicable.** *(do not complete the remaining items)*

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

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

The SEDW services to which this appendix applies are: Respite provided in a foster home, therapeutic foster care, and therapeutic overnight camp. These settings are licensed under PA 116, as amended and the rules applicable thereto. While in any of these setting the waiver service provider would administer medications as prescribed by the physician. The following rule applies to licensed family foster homes for children.
Rule 400.9411 Medical and dental care.
Rule 411.
(1) A foster parent shall follow and carry out the health plan for a foster child as prescribed by a physician, health authority, or the agency.
(2) A foster parent shall follow agency approved protocols for medical care of a foster child who is injured or ill.
(3) A foster parent shall ensure that medications are inaccessible to children unless medically necessary.
(4) A foster parent shall ensure that prescription medication is given or applied as directed by a licensed physician.

The following rule applies to licensed camps for children. R 400.11119 Health service policy. Rule 119.
(1) A camp shall have and follow a written health service policy that is appropriate to the population served and the
environment of the campsite.
(2) A camp shall establish the health service policy in consultation with, and reviewed annually by, a licensed physician.
(3) A camp's health service policy shall cover all of the following subjects:..(f) The storage and administration of prescription and nonprescription drugs and medications.

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

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

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

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

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

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

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

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

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

In addition, on-site follow-up may be provided by the site review or waiver staff regarding medication errors. During biennial site reviews, MDHHS-BHDDA verifies the process for Critical Incident Reporting is being implemented per MDHHS policy. If it is not, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP (including CMHSP affiliates as applicable) and additional follow-up by MDHHS 90 days after the corrective action plan has been approved. Post PIHP 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**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **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 substantiated abuse and neglect events reported for waiver participants. Numerator: Number of substantiated abuse and neglect events reported for waiver participants. Denominator: All SEDW 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.

Performance Measure:
Number of records being reviewed where the BTPRC policy was followed. Numerator: Number of records being reviewed where the BTPRC policy was followed. Denominator: number of records reviewed with Behavioral Treatment Plans.

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:

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.

Performance Measure:
Number of records being reviewed where the waiver participants received health care appraisal. It will also be a sample review. Numerator: number of records being reviewed where the waiver participants received health care appraisal . Denominator: number of records reviewed.

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:

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 SEDW consumers from the CIRS, as well as analyze subcategories of critical incidents reported through the CIRS including who required hospitalization due to an injury related to use of restrictive intervention or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDHHS and the Quality Improvement Council are particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effectiveness of preventive strategies. 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. As indicated elsewhere in this application, each consumer has an IPOS developed based on the child's assessed needs and strengths. The IPOS also identifies a methodology to be used by staff for addressing identified needs. Safety and crisis plans are also developed for each consumer. Required staff training includes training in the IPOS, as well as in Recipient Rights. The IPOS is overseen by the Child and Family.

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 CMHSP ORR or CMHSP, the system described in this Appendix would require the following steps be taken. Any critical incident for a participant has a short-term response to assure the immediate health and welfare of the participant for whom the incident was reported and a longer- term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the participant's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and 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 CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

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

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

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

As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random sample at the 95% confidence level for the biennial review for each PIHP/CMHSP. At the on-site review, clinical record reviews are completed to determine that the IPOS:
• Includes services and supports that align with and address all assessed needs
• addresses health and safety risks
• is developed in accordance with MDHHS policy and procedures, including utilizing person centered/family centered planning
• is updated at least annually

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

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

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

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

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

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

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

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

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

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

Quality Assessment and Performance Improvement Programs: The MDHHS contracts with PIHP/CMHSPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors, on-site, the PIHP/CMHSPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDHHS reviews on-site implementation of the following standards: Sentinel Events and credentialing of providers. MDHHS collects data for performance indicators and performance improvement projects as described in b.i. below.

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

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

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

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

ii. System Improvement Activities

Responsible Party*(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 them PIHPs/CMHSPs 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.

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

Additionally, in preparation for the SEDW renewal, the state has been in the process of identifying a valid methodology to allow for a more accurate assessment of need for the SEDW as we expand statewide. The methodology used to identify the unduplicated count for the five-year renewal is based upon the trend in growth in SEDW over the past several years. By applying this methodology, the state determined that the unduplicated count should remain at 969 for FY 2019. Beginning in FY 2019, the state plans to increase efforts to ensure that children eligible for the SEDW are identified and served statewide. Initially, efforts will focus on gathering information from stakeholders regarding obstacles to identifying and serving eligible children. A specific plan to address those obstacles will be established and implemented after an analysis of the information is completed.

External Quality Review activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. The EQR consists of desk audits of PIHP documents, two-day on-site visits to PIHPs or both. One EQR component evaluates PIHP compliance with BBA requirements. The EQR reviews the PIHP/CMHSPs' implementation of their local Quality Assessment and Performance Improvement Programs
(QAPIP) to ensure the plans include the 13 QAPIP standards. The EQR report displays performance on requirements by PIHP and can be used for trend analysis throughout the state. EQR also validates the PIHPs methodologies for conducting the State mandated project and performance indicators measurement systems.
Performance Improvement Projects: The MDHHS staff collaborates to identify the performance improvement projects for each waiver period. Justification for the projects was
derived from analysis of quality management data, external quality review findings, and stakeholder concerns. Michigan requires all PIHPs to conduct a minimum of two performance improvement projects. All PIHPs conduct one mandatory twoyear
performance improvement project assigned by MDHHS; in the case of PIHPs with affiliates, the project is affiliation-wide. All PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction are assigned a project relevant to the problem. All other PIHPs choose their second performance improvement project.

Performance Indicators: Performance indicators are used to monitor the performance of the PIHP/CMHSP on a number of domains that have been identified as important quality strategies for the mental health system. The PIHPs/CMHSPs are required to report data for performance indicators. MDHHS analyzes data against established standards, creates statewide averages and does comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action. As the need to change systems design is identified, those changes are subsequently implemented by MDHHS through revisions to PIHP and CMHSP performance requirements and practices. This is accomplished by changing or adding relevant requirements to the PIHP and CMHSP contract, Medicaid Provider Manual, and reporting requirements. Where targets or standards for systems improvement are applicable, they would be incorporated. The MDHHS site review protocols are then modified in response to the underlying changes in those requirements and subsequent MDHHS site review activities assess PIHP and CMHSP compliance with
those system design changes.

Site Review findings are reported to PIHPs/CMHSPs as described in this Appendix and throughout the CMS approved SEDW Renewal Application. In addition, a number of reports and aggregated data are available on the MDHHS web site. While these are not specific to the SEDW, they include: service utilization for children with SED; External Quality Review Summaries; summaries of Adverse Events: Medicaid Performance Indicators: summary cost and expenditure data; and other repots as required by Michigan's Legislature. Specific to the SEDW, the state is evaluating data gathered from the Child and Adolescent Functioning Tools (CAFAS), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®), the Devereux Early Childhood

Assessment Scales (DECA) and Family Status Report. The CAFAS, PECFAS and DECA are tools that measures functioning across life domain areas. This is administered at enrollment, every 3 months, and at graduation from the waiver. We also gather data specific to community placement and service array in the Family Status Report.

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

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIS is reviewed on an on-going basis by 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-MHSA/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract. If the QIC were to identify an issue that would require changes to the contract prior to the expiration of the current contract, the BHDDA could amend the contract.

Procedural changes that do not require contract changes can be implemented immediately. Additionally, if issues are identified through trending and analysis, the QIC may make recommendations to BHDDA upper management team to revise the QIS. The final decision on changes to the QIS is made by the BHDDA upper management team.

The 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-BHDDA management team and the QIC.

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

Appendix 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 Serious Emotional Disturbance Waiver 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 concurrent §1915(1115)/(c) 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 §1915(1115)/(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 SEDW services, because SEDW enrollees represent a sizable proportion of people served who have serious emotional disturbance, the report is used to note overall trends. In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend $500,000 or more in federal awards during their fiscal year must submit to MDHHS a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.
Capitation payments for the delivery of SEDW services are issued by the Medicaid agency through the new online Medicaid claims processing system [Community Health Automated Medicaid Processing System (CHAMPS)], which replaced the old Medicaid Management Information System (MMIS) claims processing system. This web-based system is used to process and pay capitation payments, e.g., monthly prepayments made on behalf of the beneficiaries of the §1915(1115)/(c) concurrent waivers, and all Medicaid fee-for-service claims. System requirements to enable processing of waiver capitation payments through CHAMPS have been incorporated into all aspects of design for this system. Significant work has been devoted to the CHAMPS/SEDW interface to assure payments are only made to a PIHP for eligible participants who are properly enrolled in the SEDW. The SEDW web-based database is the system of record for maintaining enrollment information. Each month, an interface file is transmitted from the SEDW database to the CHAMPS system for processing. Before an SEDW capitation payment is issued for a participant enrolled in the waiver, various parameters must be met, including the participant having active Medicaid eligibility. The interface from SEDW database establishes an "eligibility segment" meaning that the member meets all the requirements of enrollment into the waiver. Then CHAMPS requires that the SEDW benefit plan be opened. The SEDW benefit plan will only open once the member has obtained full Medicaid. A series of edits are in place to assure payments are only issued for participants who are eligible to receive the payment and that the payment is the correct rate based on factors determined by the actuary and approved by CMS. CHAMPS produces HIPAA-compliant 834 and 820 reports to the PIHPs to identify SEDW participants in the enrollment file and that received a capitation payment for the month.

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 capitation payments made to the PIHP only for SEDW participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHP for SEDW participants with active Medicaid eligibility. Denominator: All capitation payments for SEDW participants.

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

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

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Electronic claims submitted to Medicaid

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

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 approved 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 QMP Site Review includes an examination of the participant's IPOS and the supporting documentation that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 QMP site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by 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***

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

This §1915(c) waiver operates concurrently with the state's §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 SEDW 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:*

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to waiver agencies. The 834 process generates an enrollment file based upon the PIHP provider ID number and the beneficiary's assignment to the SEDW 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 SEDW program. 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. 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 SEDW program 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 SEDW program but the PIHPs received capitation payments due to data lags in the 834 process.

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 SEDW 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 SEDW database to CHAMPS. If the SEDW participant is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the SEDW benefit plan is opened. If the SEDW participant is non-Medicaid eligible, notification is sent back to the SEDW database advising that a particular record did not process for payment and must be resubmitted next cycle. If the SEDW benefit plan is open, the PIHP receives an electronic member file (834) containing SEDW enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the SEDW participant has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the SEDW capitation payments are made by MDHHS to the PIHPs' accounts and a payment record (820) is issued to the PIHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

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

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

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

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 SEDW 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.
The following waiver services can be provided to SEDW consumers in residential settings other than the individual's private residence: child therapeutic foster care (can be provided in a Department of Health and Human Services (DHHS) licensed foster home), and therapeutic overnight camp (can be provided in a DHHS licensed camp). DHHS, Michigan's child welfare organization, licenses and regulates children's foster care. The current approved rate for room and board is based on age and is as follows, and is not billable to Medicaid:
Age Room
Group & Board
0-12 $17.24
13-18 $20.59
The Therapeutic Foster Care rate for the SEDW is comprised of 3 components, 2 of which are billable to Medicaid; 1 which is not.
1. The daily rate covers $75.00 per day for the enhanced therapeutic rate to be paid to foster parents. This rate includes respite care (purchased by the foster parent), participation in wraparound team meetings, training and other treatment-oriented appointments for the youth and family, data collection required as part of implementing the POS (including a daily/weekly log and 24-hour supervision).
2. The daily rate also includes $35.00 per day to be paid to the provider agency. This part of the daily rate includes recruitment, pre-service training and licensing of the foster parents for this specialized service; on-going support, monitoring, training and oversight of the foster home; as well as closely supervised home visits throughout the youth's placement in the foster home.
3. Room and Board rate paid to Foster Parents: This must be paid separate from the enhanced therapeutic foster care rate and from a different funding source (e.g., Title IV-E); Medicaid cannot be used to pay this component. The room and board rate includes basic needs, including clothing, shelter, food and daily essentials. The Room and Board rate is based on the child's age:
a.) Age birth - 12: $17.24 a day
b.) Age 13 - 18: $20.59 a day
Therapeutic Overnight Camping (per session): PIHPS/CMHSPs and other approved community-based mental health and developmental disability services providers must contract with DHHS licensed camps for this service. Contracts for all providers must specify performance expectations. In the case of licensed camps, performance expectations include the length of the session and detail of all costs (e.g., cost of staff with specialized training with this population, enrollment and other camp fees, transportation to and from the camp) included in the charge for the session. The contracted rate must exclude the cost of room and board. This is accomplished in 1 of 2 ways: subtracting the applicable room & board rate (see table above) for each day of the camp session from the total charge for the session; or subtracting the cost attributed to room and board in the detailed cost of the session.

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

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

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13907.73	12048.00	25955.73	227618.00	6808.00	234426.00	208470.27
2	16025.52	12289.00	28314.52	231032.00	6945.00	237977.00	209662.48
3	18105.98	12535.00	30640.98	234497.00	7083.00	241580.00	210939.02
4	18950.48	12786.00	31736.48	238015.00	7225.00	245240.00	213503.52
5	19231.98	13041.00	32272.98	241585.00	7370.00	248955.00	216682.02

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

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

Appendix J: Cost Neutrality Demonstration

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

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

The Average Length of Stay was estimated using the State's attrition replacement enrollment management plan, wherein the State fills in behind each participant who leaves the waiver in the month immediately following their leaving/termination from the waiver, thereby maintaining the enrollment at or near the level supported by the legislative appropriation.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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

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

Estimates of Factor D at the service detail level are based on MMIS/CHAMPS data equivalent to the information previously required on the CMS 372 long form for §1915(c) Serious Emotional Disturbance Waiver and trended forward using the average rate of change for a service where the State had sufficient experience and data upon which to base the projection. The service level detail expenditures were totaled and divided by the unduplicated count of the Waiver beneficiaries who used and/or received them. The waiver template does not currently permit the State to derive Factor D from capitation payment history. If, at some future date, the template is revised to enable the State to derive Factor D using capitation payments instead of service level detail, the State can supply CMS with those figures.

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

Estimates of Factor D' are based on MMIS/CHAMPS data equivalent to the information previously required on the CMS 372 long form, i.e. Medicaid cost (fee-for-service, HMO managed care capitation payments, etc.) for all other services provided to individuals in the waiver program divided by the unduplicated count of the Waiver beneficiaries who used and/or received them, and trended forward using the average rate of change for the prior three year period. The base years' Prescribed Drug expenditures used in the projection of D' were those made on behalf of Medicaid-only waiver enrollees; that is, the costs of prescribed drugs for dual eligible individuals covered by Medicare Part D effective 1/1/06 were not included in the D' projection calculations.

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

Factor G was extrapolated from paid-claim data for used to prepare the CMS 372 report for FY17. Medicaid expenditures for psychiatric hospitalization (at Hawthorn) for FY11 were trended forward at a growth rate of 1.35% for Waiver Years 1 through 5 of the Renewal.

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

Factor G' was extrapolated from paid-claim data used to prepare the CMS 372 report for FY17. The estimated annual average per capita cost to Medicaid for all other services provided to individuals while the individual was in a psychiatric hospital was trended forward at a growth rate of 1.35% for Waiver Years 1 through 5 of the Renewal.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

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

Waiver Services	
Respite	
Child Therapeutic Foster Care	
Community Living Supports	
Family Home Care Training	
Family Support and Training	
Fiscal Intermediary	
Home Care Training, Non-Family	
Overnight Health and Safety Support	
Therapeutic Activities	
Therapeutic Overnight Camp	
Wraparound	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							2064381.69
Respite	☐	15 minutes	259	992.00	7.98	2050285.44	
Respite Per Diem	☐	Per Diem	7	9.00	223.75	14096.25	
Child Therapeutic Foster Care Total:							18661.92
Child Therapeutic Foster Care	☐	day	3	34.00	182.96	18661.92	
Community Living Supports Total:							2789769.80
Community Living Supports	☐	15 minutes	315	874.00	9.98	2747593.80	
Community Living Support-Per Diem	☐	Per Diem	4	80.00	131.80	42176.00	
Family Home Care Training Total:							397584.00
Family Home Care Training	☐	session	192	11.00	188.25	397584.00	
Family Support and Training Total:							309680.00

GRAND TOTAL:	13476590.10
Total: Services included in capitation:	
Total: Services not included in capitation:	13476590.10
Total Estimated Unduplicated Participants:	969
Factor D (Divide total by number of participants):	13907.73
Services included in capitation:	
Services not included in capitation:	13907.73
Average Length of Stay on the Waiver:	208

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Support and Training	☐	session	79	49.00	80.00	309680.00	
Fiscal Intermediary Total:							200013.00
Fiscal Intermediary	☐	session	165	10.00	121.22	200013.00	
Home Care Training, Non-Family Total:							6738.60
Home Care Training, Non-Family	☐	session	30	2.00	112.31	6738.60	
Overnight Health and Safety Support Total:							1528320.00
Overnight Health and Safety Support	☐	session	384	50.00	79.60	1528320.00	
Therapeutic Activities Total:							66936.67
Therapeutic Activities	☐	session	19	47.00	33.59	29995.87	
Activity Therapy-15 minutes	☐	15 minutes	24	13.00	118.40	36940.80	
Therapeutic Overnight Camp Total:							65315.36
Therapeutic Overnight Camp	☐	session	59	2.00	553.52	65315.36	
Wraparound Total:							6029189.06
Wraparound	☐	session	622	19.00	510.17	6029189.06	

GRAND TOTAL:	13476590.10
Total: Services included in capitation:	
Total: Services not included in capitation:	13476590.10
Total Estimated Unduplicated Participants:	969
Factor D (Divide total by number of participants):	13907.73
Services included in capitation:	
Services not included in capitation:	13907.73
Average Length of Stay on the Waiver:	208

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
Respite Total:							2399380.02
Respite	☐	15 minutes	291	1011.00	8.10	2383028.10	
Respite Per Diem	☐	Per Diem	8	9.00	227.11	16351.92	
Child Therapeutic Foster Care Total:							19498.50
Child Therapeutic Foster Care	☐	day	3	35.00	185.70	19498.50	
Community Living Supports Total:							3239023.66
Community Living Supports	☐	15 minutes	354	891.00	10.13	3195143.82	
Community Living Support-Per Diem	☐	Per Diem	4	82.00	133.78	43879.84	
Family Home Care Training Total:							453982.32
Family Home Care Training	☐	session	216	11.00	191.07	453982.32	
Family Support and Training Total:							372400.00
Family Support and Training	☐	session	95	49.00	80.00	372400.00	

GRAND TOTAL:	15528729.06
Total: Services included in capitation:	
Total: Services not included in capitation:	15528729.06
Total Estimated Unduplicated Participants:	969
Factor D (Divide total by number of participants):	16025.52
Services included in capitation:	
Services not included in capitation:	16025.52
Average Length of Stay on the Waiver:	212

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Fiscal Intermediary Total:							**228854.40**
Fiscal Intermediary	☐	15 minutes	186	10.00	123.04	**228854.40**	
Home Care Training, Non-Family Total:							**7751.32**
Home Care Training, Non-Family	☐	session	34	2.00	113.99	**7751.32**	
Overnight Health and Safety Support Total:							**1779965.28**
Overnight Health and Safety Support	☐	session	432	51.00	80.79	**1779965.28**	
Therapeutic Activities Total:							**76545.90**
Therapeutic Activities	☐	session	27	13.00	120.18	**42183.18**	
Activity Therapy-15 minutes	☐	15 minutes	21	48.00	34.09	**34362.72**	
Therapeutic Overnight Camp Total:							**74160.24**
Therapeutic Overnight Camp	☐	session	66	2.00	561.82	**74160.24**	
Wraparound Total:							**6877167.42**
Wraparound	☐	day	699	19.00	517.82	**6877167.42**	

GRAND TOTAL:	**15528729.06**
Total: Services included in capitation:	
Total: Services not included in capitation:	15528729.06
Total Estimated Unduplicated Participants:	**969**
Factor D (Divide total by number of participants):	**16025.52**
Services included in capitation:	
Services not included in capitation:	16025.52
Average Length of Stay on the Waiver:	212

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
Respite Total:							**2682157.62**
Respite	☐	15 minutes	325	997.00	8.22	**2663485.50**	
Respite Per Diem	☐	Per Diem	9	9.00	230.52	**18672.12**	
Child Therapeutic Foster Care Total:							**19791.45**
Child Therapeutic Foster Care	☐	day	3	35.00	188.49	**19791.45**	
Community Living Supports Total:							**3609202.76**
Community Living Supports	☐	15 minutes	395	878.00	10.28	**3565206.80**	
Community Living Support-Per Diem	☐	Per Diem	4	81.00	135.79	**43995.96**	
Family Home Care Training Total:							**514134.94**
Family Home Care Training	☐	session	241	11.00	193.94	**514134.94**	
Family Support and Training Total:							**372400.00**
Family Support and Training	☐	session	95	49.00	80.00	**372400.00**	
Fiscal Intermediary Total:							**403395.20**

GRAND TOTAL:	**17544690.77**
Total: Services included in capitation:	
Total: Services not included in capitation:	17544690.77
Total Estimated Unduplicated Participants:	**969**
Factor D (Divide total by number of participants):	**18105.98**
Services included in capitation:	
Services not included in capitation:	18105.98
Average Length of Stay on the Waiver:	209

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Fiscal Intermediary	☐	15 minutes	208	10.00	193.94	403395.20	
Home Care Training, Non-Family Total:							8793.20
Home Care Training, Non-Family	☐	session	38	2.00	115.70	8793.20	
Overnight Health and Safety Support Total:							1976200.00
Overnight Health and Safety Support	☐	session	482	50.00	82.00	1976200.00	
Therapeutic Activities Total:							84974.80
Therapeutic Activities	☐	session	30	13.00	121.98	47572.20	
Activity Therapy-15 minutes	☐	15 minutes	23	47.00	34.60	37402.60	
Therapeutic Overnight Camp Total:							84397.00
Therapeutic Overnight Camp	☐	session	74	2.00	570.25	84397.00	
Wraparound Total:							7789243.80
Wraparound	☐	day	780	19.00	525.59	7789243.80	

GRAND TOTAL:	17544690.77
Total: Services included in capitation:	
Total: Services not included in capitation:	17544690.77
Total Estimated Unduplicated Participants:	969
Factor D (Divide total by number of participants):	18105.98
Services included in capitation:	
Services not included in capitation:	18105.98
Average Length of Stay on the Waiver:	209

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
Respite Total:							**2810767.38**
Respite	☐	15 minutes	325	1030.00	8.34	**2791815.00**	
Respite Per Diem	☐	Per Diem	9	9.00	233.98	**18952.38**	
Child Therapeutic Foster Care Total:							**20662.56**
Child Therapeutic Foster Care	☐	day	3	36.00	191.32	**20662.56**	
Community Living Supports Total:							**3783014.83**
Community Living Supports	☐	15 minutes	395	907.00	10.43	**3736703.95**	
Community Living Support-Per Diem	☐	Per Diem	4	84.00	137.83	**46310.88**	
Family Home Care Training Total:							**521849.35**
Family Home Care Training	☐	session	241	11.00	196.85	**521849.35**	
Family Support and Training Total:							**372400.00**
Family Support and Training	☐	Session	95	49.00	80.00	**372400.00**	
Fiscal Intermediary Total:							**263660.80**
Fiscal Intermediary	☐	15 minutes	208	10.00	126.76	**263660.80**	
Home Care							**8925.44**

GRAND TOTAL:	**18363017.62**
Total: Services included in capitation:	
Total: Services not included in capitation:	18363017.62
Total Estimated Unduplicated Participants:	**969**
Factor D (Divide total by number of participants):	**18950.48**
Services included in capitation:	
Services not included in capitation:	18950.48
Average Length of Stay on the Waiver:	216

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training, Non-Family Total:							
Home Care Training, Non-Family	☐	session	38	2.00	117.44	8925.44	
Overnight Health and Safety Support Total:							2086076.72
Overnight Health and Safety Support	☐	session	482	52.00	83.23	2086076.72	
Therapeutic Activities Total:							87866.14
Therapeutic Activities	☐	session	30	13.00	123.81	48285.90	
Activity Therapy-15 minutes	☐	15 minutes	23	49.00	35.12	39580.24	
Therapeutic Overnight Camp Total:							85662.40
Therapeutic Overnight Camp	☐	session	74	2.00	578.80	85662.40	
Wraparound Total:							8322132.00
Wraparound	☐	day	780	20.00	533.47	8322132.00	

GRAND TOTAL:	18363017.62
Total: Services included in capitation:	
Total: Services not included in capitation:	18363017.62
Total Estimated Unduplicated Participants:	969
Factor D (Divide total by number of participants):	18950.48
Services included in capitation:	
Services not included in capitation:	18950.48
Average Length of Stay on the Waiver:	216

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
Respite Total:							**2854569.19**
Respite	☐	15 minutes	325	1030.00	8.47	**2835332.50**	
Respite Per Diem	☐	Per Diem	9	9.00	237.49	**19236.69**	
Child Therapeutic Foster Care Total:							**20972.52**
Child Therapeutic Foster Care	☐	day	3	36.00	194.19	**20972.52**	
Community Living Supports Total:							**3841032.75**
Community Living Supports	☐	15 minutes	395	907.00	10.59	**3794026.35**	
Community Living Support-Per Diem	☐	Per Diem	4	84.00	139.90	**47006.40**	
Family Home Care Training Total:							**529669.80**
Family Home Care Training	☐	session	241	11.00	199.80	**529669.80**	
Family Support and Training Total:							**372400.00**
Family Support and Training	☐	Session	95	49.00	80.00	**372400.00**	
Fiscal Intermediary Total:							**267612.80**
Fiscal Intermediary	☐	15 minutes	208	10.00	128.66	**267612.80**	
Home Care Training, Non-Family Total:							**9059.20**

GRAND TOTAL:	**18635790.87**
Total: Services included in capitation:	
Total: Services not included in capitation:	18635790.87
Total Estimated Unduplicated Participants:	**969**
Factor D (Divide total by number of participants):	**19231.98**
Services included in capitation:	
Services not included in capitation:	19231.98
Average Length of Stay on the Waiver:	216

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Non-Family	☐	session	38	2.00	119.20	9059.20	
Overnight Health and Safety Support Total:							2117406.72
Overnight Health and Safety Support	☐	session	482	52.00	84.48	2117406.72	
Therapeutic Activities Total:							89188.85
Therapeutic Activities	☐	session	30	13.00	125.67	49011.30	
Activity Therapy-15 minutes	☐	15 minutes	23	49.00	35.65	40177.55	
Therapeutic Overnight Camp Total:							86947.04
Therapeutic Overnight Camp	☐	session	74	2.00	587.48	86947.04	
Wraparound Total:							8446932.00
Wraparound	☐	day	780	20.00	541.47	8446932.00	

GRAND TOTAL:	18635790.87
Total: Services included in capitation:	
Total: Services not included in capitation:	18635790.87
Total Estimated Unduplicated Participants:	969
Factor D (Divide total by number of participants):	19231.98
Services included in capitation:	
Services not included in capitation:	19231.98
Average Length of Stay on the Waiver:	216