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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
MI Health Link HCBS

C. Waiver Number:MI.1126

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
01/01/21

Approved Effective Date of Waiver being Amended: 01/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

1. Modifications to performance measure related to education about abuse, neglect, exploitation, and other critical incidents to clarify where the documentation should be found and the time period for review.

2. Modifications to the performance measure related to Individual Integrated Care and Supports Plan (IICSP) individualized goals.

3. Retire performance measure pertaining to the timeliness of the IICSP.

4. Addition of a performance measure related to required monthly contact between the ICO and the waiver enrollee.

5. Clarification that the service definition for respite includes:
a.Attendant care (enrollee is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
b.Basic care (enrollee may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

6. Addition of clarifying guidance related to critical incident reporting requirements when multiple incident types occur on the same day for the same beneficiary.

7. Modifications to the limitations for the environmental modifications service to exclude homes in the foreclosure process. Additionally, language will be added

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Main 6I; Main 8A Attachment 1
☒ **Appendix A Waiver Administration and Operation**	Quality Improvement
☐ **Appendix B Participant Access and Eligibility**	
☒ **Appendix C Participant Services**	1
☒ **Appendix D Participant Centered Service Planning and Delivery**	Quality Improvement
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F**	

Component of the Approved Waiver	Subsection(s)
Participant Rights	
☒ Appendix G Participant Safeguards	Gb;Quality Improvement
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

New limits added to the Environmental Modification service, as well as the addition of language to add clarity to the service specification. Additionally, this amendment will include revisions to performance measures.

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*):

MI Health Link HCBS

C. Type of Request: amendment

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**

Draft ID: **MI.029.01.01**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/20
Approved Effective Date of Waiver being Amended: 01/01/20

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:

MI Health Link HCBS is limited to serving older adults (age 65 and over) and persons with disabilities (age 21 and over) who are eligible for both Medicare and Medicaid.

○ **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:

A 1915(b) waiver application has been previously approved under CMS control number MI 19.R00.00 and MDHHS is seeking renewal of this 1915(b) waiver concurrent to request for renewal of this 1915(c) waiver.

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:

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.

MI Health Link is a program that coordinates supports and services for individuals who are dually eligble for both Medicare and Medicaid programs and reside in any one of the four regions as indicated in section 4(C) of this application, and meet the following other eligibility criteria:

Included population:
Individuals who are aged and/or disabled, age 21 or older, eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, receiving full Medicaid benefits, and living in Region 1, 4, 7, or 9. Also included are individuals who are eligible for Medicaid through expanded financial eligibility limits associated with nursing facility placement or under a 1915(c) HCBS waiver.

Excluded population:
• Persons without full Medicaid coverage.
• Persons with Medicaid who reside in a State psychiatric hospital.
• Persons with commercial HMO coverage.
• Persons with Medicare Advantage through an employer.
• Persons disenrolled due to Special Disenrollment from Medicaid managed care.
• Persons incarcerated in a city, county, State, or federal correctional facility.
• Persons not living in a Demonstration region.
• Persons with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI).
• Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or the MI Choice waiver program.
• Persons residing in a State VA Home (as of June 1, 2018)
• Individuals under age 21 who participate in the Children's Special Health Care Services (CSHCS) program operating under the authority of Title V.
• Certain individuals identified in accordance with the Comprehensive Addiction and Recovery Act (CARA) of 2016 42 CFR 423.153(f).

Medicare and Medicaid supports and services are provided through managed care organizations called Integrated Care Organizations (ICOs) under a three-way contract with CMS and MDHHS. All enrolled individuals may receive Medicaid State Plan physical health care supports and services through the MI Health Link §1915(b) waiver. This MI Health Link §1915(b) waiver operates concurrently with the §1915(c) waiver called MI Health Link HCBS. The MI Health Link HCBS waiver offers home and community-based services (HCBS) to MI Health Link enrollees who are elderly and/or physically disabled, dually eligible for Medicare and Medicaid, and meet nursing facility level of care.

Under the entire MI Health Link §1915(b)/(c) waiver program, there are three capitation rate Tiers in which enrollees may be placed based on their needs. Tier 1 is for enrollees who reside in nursing facilities. Tier 1 enrollees will be given the choice of remaining in the nursing facilities or transitioning to the community and receiving home and community based services (HCBS). Tier 2 is for enrollees who participate in the MI Health Link HCBS waiver. Tier 2 enrollees would, if not for the provision of such home and community based services, require services in a nursing facility. The goal is to provide home and community based supports and services to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. Tier 3 is for enrollees living in the community but are not eligible for MI Health Link HCBS. Michigan’s Nursing Facility Level of Care Determination (NFLOCD) tool will be used to determine in which Tier an enrollee will be placed. Tier 1 enrollees may transition to the MI Health Link HCBS waiver and would then become under the Tier 2 category.

The waiver is administered by the Michigan Department of Health and Human Services (MDHHS), Medical Services Administration (MSA), which is the Single State Agency. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations. CMS and MDHHS contract with Integrated Care Organizations (ICOs) to provide services to MI Health Link enrollees and carry out the waiver obligations. The ICOs are paid a monthly capitation rate for services rendered to MI Health Link enrollees. Each ICO must sign a provider agreement with MDHHS assuring that it meets all program requirements. ICOs may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under contract or subcontract with the ICO must meet provider standards described elsewhere in the waiver application. Provider contracts or subcontracts also assure that providers of services receive full reimbursement for services outlined in the waiver application. Providers meeting the requirements outlined in the waiver are permitted to participate.

MI Health Link §1915(b)/(c) waiver program enrollees also may receive supports and services for needs related to behavioral health, intellectual/developmental disability, or substance use disorders through the PIHPs under the Michigan 1115 Behavioral Health Demonstration. ICOs are required to work with the PIHPs to coordinate all supports and services for enrollees.

Participants enrolled in the MI Health Link HCBS waiver may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ( ) **No**
- (●) **Yes**

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

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

The demonstration will be implemented in four regions in the state:

– Region 1 (Upper Peninsula) – Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft Counties

– Region 4 (Southwest) – Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren Counties

– Region 7 (Wayne) – Wayne County

– Region 9 (Macomb) – Macomb County

☐ **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:

Relative to the Waiver Amendment two notices went out from MDHHS as follows:
-L 20-46 distributed 7-30-2020 To all Tribal Chairs and Health Directors notifying them of the State's intent to submit this waiver amendment with comment period through 9-12-2020. No Comments were received.

-L 20-48 was distributed on 8-3-2020 to Prepaid Inpatient Health Plans, Integrated Care Organizations, and Interested Stakeholders notifying them of the State's intent to submit this waiver amendment. A comment period exhausted on 9-15-2020. See below for comments and responses related to proposed changes. The full consultation summary that contains general comments and comments about existing waiver language will be sent separately to CMS as character limits prevented including it all within this response.

-A newspaper forum was used for notification of the amendment. This public notice was made 8-4-2020 in multiple newspapers with comment period through 9-15-2020. No comments were received.

Tribal Notice: distributed 7-30-2020 with comment period through 9-12-2020
Stakeholder Letter: distributed 8-3-2020 with comment period through 9-15-2020
Public Notice: made 8-4-2020 with comment period through 9-15-2020

The amendment application was posted to the MI Health Link website, available at:
https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html

Comments Related to Proposed Changes:
Re: Appendix A: Waiver Administration and Operation; addition of a new PM about 30 day contact with beneficiary. This is a great addition, and we would welcome a similar measure outside the waiver for regular contact with beneficiaries in long term care facilities.
Response:
Thank you for your feedback. Our current 3 way contract authority mandates that beneficiaries on the waiver are high risk and thus require monthly contact. Currently, Integrated Care Organizations (ICOs) determine which risk category beneficiaries in long term care facilities (outside of the waiver) fall into which in turn determines the requirements for regular contact. We will consider your suggestion as we consider proposals for future contract revisions.
Re: Appendix C: Participant Services C-1/C-3: Service Specification
Proposed Language: “The modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The modification cannot result in valuation of the structure significantly above comparable neighborhood real estate values.” This language is problematic for a myriad of reasons.
Response:
This language was added to the MHL waiver, as noted, to align with other 1915c waiver applications within MDHHS that offer the same service. We have decided to remove the following language from the waiver amendment pending further internal discussion: “The modification cannot result in valuation of the structure significantly above comparable neighborhood real estate values.”
We are interested in continuing discussions on this subject with the Michigan Elder Justice Initiative (MEJI)/MI Health Link Ombudsman (MHLO) and the other waiver programs to determine a unified statewide approach in developing future amendments to the service specification for Environmental Modifications.
Re: Appendix G: Participant Safeguards Quality Improvement: Health and Welfare
Proposed Language: Number & percent of enrollee files that reflect enrollee or their legal guardians received info & education about how to report abuse, neglect, exploitation & other critical incidents w/in 60 days of waiver enrollment. Numerator: Number of enrollee files that reflect enrollee or their legal guardians received the ANE/CI info and education w/in 60 days. Denominator: Number of enrollee files reviewed.
The old language in this performance measure is weaker than other language related to training on abuse, neglect, and exploitation elsewhere in the waiver. Earlier in Appendix G-1c. there is language that states ICOs “will train participants and their families or legal representatives on how to identify and report suspected abuse, neglect and exploitation, including where to report incidents” (emphasis added). The performance measure here is for training for the “enrollee or their legal guardians” (emphasis added).
The language in the performance measure is much weaker because the “or” allows ICOs to meet the measure even if it is only the legal guardian who receives the information and education on ANE/CI. There is nothing that says both the guardian and the enrollee need this information and education, which could be a huge problem in a case where the guardian themselves are the abuser and the enrollee has no idea what steps to take to report and prevent the abuse. Therefore, we recommend that additional changes be made to this measure beyond the proposed modifications: MDHHS should also modify the measure to align with the other waiver language

and require that the enrollee and their legal guardians or families must receive the ANE/CI info and education in order to satisfy the measure.
Response:
Thank you, following consideration of your feedback, we have revised the performance measure to read, “Number & percent of files that show enrollee/family/legal guardians(as appropriate) received info & education on how to report abuse, neglect, exploitation & other critical incidents w/in 60 days of waiver enrollment. Numerator: Number of files that show enrollee/family/legal guardians (as appropriate) received the ANE/CI info & education w/in 60 days. Denominator: Number of enrollee files reviewed.” Please note that the waiver portal limits the performance measure to a 400 character count.

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, Actuarial Division

Address: P.O. Box 30479

Address 2: 400 S. Pine, 7th Floor

City: Lansing

State: **Michigan**

Zip: 48909-7979

Phone: (517) 248-1190 **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 the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The following new limits have been added to the environmental modification service:
-homes in a foreclosure process will be excluded from being eligible for environmental modifications
-modifications that would result in valuation of the structure significantly above comparable neighborhood real estate values will be restricted.

These new limits will be effective upon the effective date of this amendment and apply when environmental modifications are authorized following this effective date. The new limits will not affect beneficiaries that have received this service prior to the amendment effective date.
If these limits cause an otherwise eligible individual to be ineligible for this waiver service their health and safety will be assured through the assessment and care planning process. If a need is identified, the individual's care coordinator can work with them to identify alternate interventions (i.e. alternate housing, community resources) to meet their needs.
These new limits will not effect any environmental modifications authorized/in progress prior to the effective date of this amendment.

Enrollees are notified of any applicable service limitations (including this change) by the Integrated Care Organization responsible for administering their waiver services.

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.

Since MI Health Link was a new program at the time of the HCBS Final Rule, it was required to be in compliance with the Final Rule requirements since its inception. The Statewide Transition Plan focuses on assuring compliance for programs that were in existence prior to the Final Rule that were offered time to transition into compliance.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

1. Transitioning to MI Health Link from other programs:

MI Health Link is a voluntary program, allowing individuals to opt out if they so choose. Individuals who are enrolled in the MI Choice waiver program are not passively enrolled into MI Health Link and are not required to enroll. It is entirely the individual's choice as to whether or not he or she wants to disenroll from MI Choice to join MI Health Link. Individuals who enroll in MI Health Link will benefit from the extensive coordination of Medicare, Medicaid, and MI Health Link HCBS services.

Individuals who make the choice to transition from MI Choice to MI Health Link HCBS will not lose any services, but some services similar to MI Choice will be offered through the Medicaid State Plan through the ICOs or the Michigan 1115 Behavioral Health Demonstration through the PIHPs. MI Choice offers hands-on assistance for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as a waiver service. MI Health Link HCBS offers the same assistance but through the Medicaid State Plan Personal Care benefit. Similarly, MI Choice offers Community Living Supports (CLS) as a waiver service, and MI Health Link offers Expanded Community Living Supports (ECLS) as a waiver service, but the definition for ECLS is different from the MI Choice CLS to avoid duplication between Medicaid State Plan Personal Care services and ECLS. The assistance is still offered, but through different specific services -- enrollees may receive both services if they qualify. MI Health Link HCBS does not offer the MI Choice Goods and Services service, but ICOs may provide similar items through an optional flexible benefit. MI Health Link HCBS does not offer Counseling and Training as a waiver service, but these services will be provided through the Michigan 1115 Behavioral Health Demonstration program managed by Michigan's PIHPs.

ICOs are required to maintain continuity of care for all individuals transitioning to MI Health Link from different programs. Individuals transitioning from MI Choice to the MI Health Link HCBS will be able to keep their current plans of care, services, and providers for 90 days or until a new Individual Integrated Care and Supports Plan (IICSP) is developed and new services and providers are secured, whichever is sooner. The MI Health Link continuity of care requirements are outlined in the Memorandum of Understanding (MOU) with CMS and the three-way contract among CMS, MDHHS, and ICOs.

If a MI Health Link HCBS enrollee chooses to disenroll from the MI Health Link program and participate in MI Choice, the transition will be carefully planned with care coordination between ICOs and MI Choice waiver agencies so there is no interruption in service. If an individual was enrolled in MI Choice prior to enrolling in MI Health Link within the same fiscal year, he or she will be able to re-enroll into their MI Choice waiver slot if there has been no disruption in long term supports and services (LTSS). If there is a disruption in LTSS or the transition happens in a new fiscal year from previous MI Choice enrollment, the individual will be required to be placed on the MI Choice waiting list until a vacancy occurs.

Individuals who disenroll from another program to enroll in MI Health Link will receive a disenrollment letter indicating they are no longer enrolled in the program in which they were enrolled and the letter will include information about the right to a State Fair Hearing and other appeals options. To enroll in MI Health Link, individuals will contact the State's enrollment broker to enroll. The enrollment broker will send the individual an enrollment letter notifying him or her of enrollment in the MI Health Link program and the ICO that was either automatically assigned or chosen by the individual. The enrollment letter will also indicate what the individual should do if the enrollment is a mistake, including the right to a Fair Hearing. If an enrollee chooses to disenroll from the program, he or she would contact the enrollment broker to disenroll. The enrollment broker sends the individual a disenrollment letter which includes the right to a Fair Hearing and what to do if he or she thinks the disenrollment is a mistake.

Personal care services offered under the State Plan benefit will be the same as those in MI Choice at least throughout the 90-day transition period. The language in the Three-Way Contract is as follows: "MI Choice HCBS waiver enrollees: Maintain current providers and level of services at the time of Enrollment for ninety (90) calendar days unless changed during the Person-Centered Planning Process." After the initial transition period, the amount, scope, and duration may change through the person-centered planning process and based on a new assessment.

MDHHS wants to ensure that individuals have made an informed choice prior to disenrolling from the MI Choice program. MI Choice participants are a voluntary population in the sense that they need to actively make the choice to disenroll from MI Choice and enroll in MI Health Link; otherwise they will not be enrolled. If the individual calls the enrollment broker to enroll in MI Health Link, the enrollment broker will be able to identify the individual as a current MI Choice participant. Prior to the individual disenrolling from MI Choice and enrolling in MI Health Link, the enrollment broker will contact MDHHS staff and also tell the individual that he or she needs to work with MDHHS MI Health Link staff to determine if the MI Health Link program is suitable for him or her. MDHHS staff will work with the individual, the MI Choice waiver agency, and the MDHHS MI Choice program staff to obtain the individual's current Nursing Facility Level of Care Determination and supporting documentation, current service plan, current providers, information about the current residential setting, and any other necessary information. MI Health Link staff will evaluate the individual's service needs and determine whether the MI Health Link/MI

Health Link HCBS services can meet his or her needs. This evaluation will also include an assessment of the current residential and non-residential settings to ensure compliance with the HCBS Final Rule. If the individual's needs can be met through the MI Health Link program, and the residential and non-residential settings are in compliance with the HCBS Final Rule, MDHHS MI Health Link staff will discuss with the individual his or her options to enroll in MI Health Link or remain in MI Choice. Differences in services and other program nuances will be clearly conveyed to the individual. Being fully informed of options, the decision will then be up to the individual as to whether he or she wants to remain in MI Choice or disenroll from MI Choice and enroll in MI Health Link. MDHHS MI Heath Link staff will notify MDHHS MI Choice staff about the individual who may disenroll from MI Choice and the two MDHHS program areas will coordinate any MI Choice disenrollments and MI Health Link enrollments. Once the individual disenrolls from MI Choice with the necessary paperwork and level of care code changes in the system, the individual will choose an ICO and will be entered into the MI Health Link HCBS waiver enrollment database. Services will be maintained at least until different arrangements are made via the person-centered planning process.

a. If the individual's residential and non-residential settings are not in compliance with the HCBS Final Rule, the individual will be informed that he or she must move to a different setting prior to enrolling in MI Health Link. If the MI Health Link program cannot otherwise meet the individual's needs, MDHHS MI Health Link staff will inform the individual of this so he or she does not disenroll from MI Choice and later realize he or she made a big mistake when services are not available.

b. Prior to disenrollment from the MI Choice program, MDHHS will also notify individuals of the potential for being placed on a waiting list if they choose to disenroll from MI Health Link and return to MI Choice.

A similar process will be in place for individuals who choose to disenroll from the Program of All-Inclusive Care for the Elderly (PACE) to enroll in MI Health Link.

MDHHS has conducted an assessment of residential and non-residential settings to evaluate whether they are in compliance with the HCBS Final Rule. Additionally, during the Readiness Review process, ICOs were required to submit their provider networks to CMS and MDHHS for approval to ensure that provider networks do not include settings that have been excluded by the State. MDHHS evaluates the residential and non-residential settings that are submitted by ICOs to ensure they are in compliance with the Final Rule prior to approval in the provider network. In order for MDHHS to ensure that settings are compliant prior to enrollment of the individual into the MI Health Link HCBS waiver, and that the list of compliant/non-compliant settings is as current as possible for ongoing monitoring purposes, MDHHS will evaluate residential settings, and non-residential settings as necessary, prior to approving the individual for participation in the waiver. This also applies to individuals who are interested in coming to MI Health Link from MI Choice as mentioned above. MDHHS assures CMS that all residential and non-residential settings associated with the MI Health Link HCBS waiver are in compliance with the HCBS Final Rule. Settings were assessed prior to submission of the waiver application.

2. Monitoring of Service Utilization
MDHHS will monitor service utilization for all MI Health Link HCBS enrollees, but especially for those individuals under the expanded eligiblity group who are only eligible for Medicaid when enrolled in a 1915(c) waiver or residing in a nursing facility. Monitoring of service utilization and enrollment of individuals under the expanded eligibility group will provide MDHHS with information to determine if future changes need to be made to how services are delivered.

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:

Michigan Department of Health and Human Services, Medical Services Administration

(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.

(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:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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.:*

CMS and MDHHS have entered into a three-way contract with regional non-state managed care entities known as Integrated Care Organizations (ICOs) to conduct operational, administrative, and care coordination functions for the waiver. ICOs are also responsible for the following functions: disseminating information to potential participants and assisting individuals with applying for enrollment; managing enrollments to ensure the ICOs operate within their maximum allocated number of participants; and ensuring that other evaluations and assessments are completed within the required timeframes as set forth in policy; reviewing each participant's Individual Integrated Care and Supports Plan (IICSP) to ensure appropriateness of waiver services in the amount, scope, and duration necessary to meet the participant's needs; and conducting prior authorization and utilization management of waiver services; performing quality assurance and quality improvement activities. ICOs will also be required to complete the Nursing Facility Level of Care Determination (NFLOCD) tool and submit to CHAMPS for final approval of whether the individual meets nursing facility level of care (NFLOC).

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The Integrated Care Division, located within the Bureau of Medicaid Long Term Care Services and Supports, in the Medical Services Administration of the Michigan Department of Health and Human Services, is responsible for assessing the performance of each ICO.

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:

CMS and MDHHS have established a Contract Management Team consisting of CMS staff and/or their contractors as well as MDHHS staff. The Contract Management Team evaluates and monitors ICO performance and compliance with the three-way contract, requirements set forth in the MI Health Link §1915(b)/(c) waiver as approved by CMS, and any other applicable policies and procedures. The Contract Management Team will do the following:

- Monitor ICO compliance with the Three-Way Contract;
- Coordinate periodic audits and surveys of the ICO;
- Receive and respond to complaints;
- Conduct regular meetings with the ICO;
- Provide technical assistance to the ICO;
- Try to resolve any conflicts related to the Three-Way Contract;
- Inform the ICO of any action that needs to be taken by CMS or MDHHS in relation to ICO compliance with the Three-Way Contract;
- Review marketing materials and other policies and procedures;
- Coordinate review of any grievances or appeals;
- Review reports from the MI Health Link ombudsman program;
- Review stakeholder input about ICO performance and any other systemic issues.

MDHHS has also developed a Quality Strategy that is applicable to the entire MI Health Link 1915(b)/(c) program. The MI Health Link Quality Strategy monitors ICO performance on many quality indicators as required by CMS and in compliance with 42 CFR 438 Managed Care rules. The quality assurance areas covered under this Quality Strategy are related to Access Standards, Adequacy of Capacity and Services, Coordination and Continuity of Care, and Structure and Operations Standards. The Quality Strategy includes performance measures from Healthcare Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data, Health Outcomes Survey, enrollment and disenrollment reports, External Quality Review reports, quality withhold performance indicators, reports of enrollee complaints, network adequacy, and other ratings and measures, and direct stakeholder input.

MDHHS also oversees performance of ICOs through the Quality Improvement Strategy as described in this MI Health Link HCBS waiver. ICOs will be evaluated on their performance related to assurance of the following: appropriate enrollment in the waiver; appropriate level of care determinations made prior to enrollment in the waiver and ongoing; review and periodic updates of Individual Integrated Care and Supports Plans (IICSP); residential and non-residential settings are compliant with the HCBS Final Rule; providers meet specified provider qualifications; the enrollee has a choice of services and providers; health and safety of the enrollee; monitoring and reporting of critical incidents, restraints, seclusions, or restrictive interventions; monitoring and reporting of suspicious or unexpected deaths and injury due to medication error; ensuring training has occurred for reporting critical incidents; ensuring that critical incidents were reported within specific timeframes; ensuring capitation payments were made appropriately for enrollees with Program Enrollment Type ICO-HCBS or ICO-HOSW; and encounters are submitted timely and correctly.

MDHHS also oversees enrollee approval for enrollee participation in the MI Health Link HCBS waiver. ICOs will compile information including medical records, the NFLOCD results (ensuring in CHAMPS), the current IICSP, and any other necessary information for enrollees who wish to participate in this waiver and send the information to MDHHS for approval. MDHHS staff will review the information and approve enrollment in this waiver if appropriate. MDHHS will change the Program Enrollment Type to ICO-HCBS in the system. The change may be done through the State's Bridges eligibility system either manually or automatically via an interface between Bridges and the Waiver Management Database.

MDHHS developed a Waiver Management Database which allows MDHHS to monitor certain activities related to enrollee participation in this waiver. The activities MDHHS will be able to monitor include the following: waiver enrollment, disenrollment, capacity and “slot” utilization, and submission of waiver application materials. The system also offers the capability for enrollee-specific electronic communication between MDHHS and ICOs.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of enrollees enrolled in MI Health Link HCBS consistent with MDHHS policies and procedures. Numerator: Number of qualified enrollees enrolled consistent with policies and procedures. Denominator: All beneficiary files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Support Application

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: ICOs	☒ **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**

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

Performance Measure:
Number & percent of beneficiary records that reflect the ICO is making monthly contact(or documenting why contact not made e.g.unable to reach)w/ beneficiary for each month of waiver enrollment. Numerator: Number of records that reflect the ICO is making monthly contact w/ beneficiary(or documenting why contact not made e.g. unable to reach). Denominator: Number of beneficiary records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
record reviews on or offsite, other reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Proportionate Random Sample 95% Confidence Level with +/-5% margin of error
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

ICOs		
	☒ **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 & percent of residential/non-residential settings surveyed that comply with the HCBS Final Rule or as otherwise approved by CMS. Numerator: Number of residential/non-residential settings surveyed that comply with the HCBS Final Rule. Denominator: All residential/non-residential settings surveyed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Support Application, Surveys, Setting Visits

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: ICO/assigned contractor if applicable	☒ **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 corrective action plans (CAPs) that were submitted by ICOs according to CAP process requirements set by MDHHS. Numerator: Number of corrective action plans that were submitted by ICOs according to CAP process requirements set by MDHHS. Denominator: All corrective action plans submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports submitted to MDHHS, other documents submitted to MDHHS

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: ICO	☒ **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 appropriate LOC determinations found after MDHHS review.
Numerator: Number of appropriate LOC determinations found after MDHHS review.
Denominator: Number of LOC determinations reviewed by MDHHS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
State NFLOC system

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 conducts the following monitoring processes in addition to the quality assurance reviews:
1. Routinely monitors encounter and capitation data from the Medicaid data warehouse.
2. Verifies active licensure via a public website for each registered nurse and social worker employed at the ICO annually or sooner if the ICO provides an updated personnel list.
3. Routinely reviews, analyzes, and compiles all MI Health Link administrative hearings and appeals decisions and takes corrective action when an ICO is non-compliant with a decision and order resulting from an administrative hearing.
4. As needed, investigates and monitors through resolution complaints received regarding operations of the MI Health Link waiver program. This process might involve discussion with the ICO, enrollees or their representatives, the Michigan Department of Health and Human Services (DHHS)local office, or any other entity that might be helpful in producing a resolution.
5. Routinely monitors, reviews, and evaluates the Critical Incidence Management Reporting System.
In addition, MDHHS performs the following functions:
a. MDHHS has a Provider Monitoring Program to ensure all waiver service providers meet provider qualifications.
b. MDHHS provides administrative oversight of provider approvals, sanctions, suspensions, and terminations by the ICOs.
As part of the contract between MDHHS and the ICOs, MDHHS outlines steps ICOs can require as part of provider corrective action plans. ICOs send all provider monitoring reports, including corrective action plans, to MDHHS. MDHHS reviews these reports and may request additional information.

b. Methods for Remediation/Fixing Individual Problems

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

If any inappropriate LOC determinations are found, the LOC determination will need to be conducted again within two weeks of the finding.
If any enrollee is being served but does not qualify for the program, the ICO must help the enrollee find alternative services in the community and begin the disenrollment process including providing the enrollee with appeal rights. MDHHS will recover all Medicaid capitation payments made during any period of ineligibility and pay ICOs the correct capitation payment, as applicable if the individual is still eligible for other physical health services offered through MI Health Link.
MDHHS assures CMS that all residential and non-residential settings associated with the MI Health Link HCBS waiver are in compliance with the HCBS Final Rule prior to inclusion in the waiver and also with ongoing monitoring throughout the duration of the waiver. Any new settings that the ICO chooses to add to their provider network must be approved by MDHHS for HCBS Final Rule compliance. MDHHS's continual approval and monitoring of the settings throughout the duration of the waiver will ensure that ICOs are not using settings that have previously been added to the list of excluded settings and that still need to be excluded. Additionally, the continued monitoring will help MDHHS to identify any settings which were previously excluded but have since brought themselves into compliance. If the ICOs have selected settings that are noncompliant, the ICOs will be required to select different settings and resubmit to MDHHS for review and approval.

If a setting is determined to not be home and community-based,ICOs are required to find another service provider and allow the enrollee to choose among providers. The State understands that all residential and non-residential settings must comply with CMS regulations and the HCBS Final Rule. The State will conduct ongoing monitoring to ensure settings that have been determined to be compliant with the Final Rule remain in compliance. The process for ongoing monitoring will occur 1) prior to each enrollee being approved for participation on the waiver, 2) via data collection for the two performance measures in the Quality Improvement Strategy included in this application, and 3) MDHHS requiring the ICO to submit any changes to the provider network to MDHHS for approval.If a setting which was compliant falls out of compliance, the State will work to maintain services and continuity of care for the enrollee until the setting is back in compliance or a new setting has been selected by the enrollee. Throughout the monitoring process, the State will also be looking for any settings-related patterns or systemic issues that may need to be addressed by policy or contract changes, and will address those issues and make necessary changes to policy or contracts. If the enrollee is disenrolled from MI Health Link HCBS, the ICO is required to provide him or her with an integrated notice of denial of medical coverage and right to Fair Hearing.

After completing the quality assurance reviews, MDHHS conducts exit conference with the ICO staff. During the exit conference, the ICO is provided with a summary report of findings including any findings that require immediate remediation. The immediate remediation is due within 72 hours. MDHHS also compiles quality assurance review findings from annual audits, critical incident reviews and provider monitoring reviews into draft reports that are sent to the ICO. The ICO will receive a rebuttal period of 5 business days in which they can submit documentation not previously reviewed to support reconsideration of findings. MDHHS will make any revisions to the draft reports as appropriate and the ICO will receive a final report. When the final report indicates a need for corrective action, the ICO has 30 calendar days to respond with a corrective action plan (CAP) utilizing MDHHS template.
Corrective action plans should demonstrate that the ICO has:
1.Analyzed all non-evident findings and determined possible causes;
2.Developed a remediation strategy, including timelines, that address and resolve the problems; and
3.Planned ongoing monitoring of remediation activities and performance.
MDHHS will review the CAP and will accept or request a resubmission. If accepted, the plan will have 90 calendar days to implement. If a resubmission is requested, the plan will be required to update the CAP and resubmit within 7 calendar days. After second submission, if the CAP is not accepted, MDHHS will execute sanctions in accordance with the Three Way Contract until a submitted CAP is accepted. MDHHS may request an independent validation audit in accordance with MDHHS and CMS requirements.
MDHHS will monitor the implementation of the CAP. ICOs are required to provide evidence of their remediation strategy by submitting documentation to MDHHS following the implementation phase utilizing MDHHS template. This documentation might include training materials, revised policies and procedures, information from staff meetings or case record documentation to support the corrective action plan has been implemented. Ongoing monitoring will occur as needed.

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: ICOs	☒ **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**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	21	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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			

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

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

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

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

Specify:

Participants in MI Health Link who are eligible due to a physical disability and reach age 65 are then deemed to have continued program eligibility by virtue of their age as long as they remain eligible for both Medicare and Medicaid. No transition is necessary within the program.

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	4974
Year 2	5077
Year 3	5181
Year 4	5284
Year 5	5388

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	4674
Year 2	4777
Year 3	4881
Year 4	4984
Year 5	5088

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).**

Purpose(s) the state reserves capacity for:

Purposes
Nursing facility transitions and individuals with imminent risk of nursing facility admission

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Nursing facility transitions and individuals with imminent risk of nursing facility admission

Purpose *(describe):*

MDHHS is reserving a small number of slots for temporary waiver enrollment in the event an ICO has used all of its capacity and there is an individual with imminent risk of nursing facility admission if not for availability of waiver services, or an individual is transitioning from a nursing facility into the community. MDHHS will "own" the reserved slots and will loan a slot to the ICO temporarily until another individual disenrolls from this waiver creating a vacancy at the ICO. Once a vacancy occurs with the ICO, MDHHS will take back the loaned slot and reserve the slot for another individual who needs it. This process is to ensure an individual can enroll in this waiver without a delay waiting for an ICO to have a vacant slot.

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined by calculating 1/3% of the total expected unduplicated enrollee count for this waiver for each waiver year. If that number resulted in a decimal, it was rounded up to the nearest whole number.

If this application is viewed under the printable view, only the first three waiver years for reserved capacity show up on the page. To provide clarity for reviewers and commenters, the reserved capacity in the chart below for all five waiver years is:

Year 1: 16
Year 2: 17
Year 3: 17
Year 4: 17
Year 5: 18

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	16
Year 2	17
Year 3	17
Year 4	17
Year 5	18

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:

(a) Michigan operates its waiver through Integrated Care Organizations (ICOs).

(b) The initial allocation of waiver capacity was based on anticipated demand in each region. This anticipated demand was based on number of Medicare-Medicaid eligibles enrolled in MI Choice, the number of individuals on the MI Choice waiver waiting list, enrollment experience for the MI Choice waiver, and individuals who have been determined to meet nursing facility level of care.

(c) MDHHS will continuously monitor waiver capacity for each ICO. If ICOs are underutilizing the waiver or are constantly at capacity, the waiver capacity allocation will be reconsidered and adjusted if needed.

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

All applicants for the MI Health Link HCBS waiver must meet nursing facility level of care requirements as determined by a qualified professional using the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD). After this evaluation, MDHHS requires that applicants receive information on all programs for which they qualify. Applicants then indicate the program of their choice and document the receipt of information regarding their options by completing the Michigan Freedom of Choice form. This form must be signed and dated by the applicant (or his or her legal representative) seeking services and is to be maintained in the applicant's case record.

When the number of enrollees applying for services exceeds program capacity, a procedure is implemented giving priority in descending order to the following groups for enrollment in the program:

1. Qualified applicants diverted from an imminent nursing facility admission including any applicant with an active Adult Protective Services (APS) case who qualifies for and could benefit from Integrated Care services;

2. Nursing facility residents who meet program requirements, express a desire to return to a home and community based setting, and need services over and above those provided outside this waiver in order to live successfully in the community;

3. All other qualified applicants in chronological order by date of inquiry.

Category 1 has the highest priority and is admitted first. Then, applicants in Category 2 followed by applicants in Category 3 are admitted. Within each category, applicants are admitted by date of application.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- (●) **No**
- ( ) **Yes**

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

limits under the plan. *Check all that apply*:

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:
- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

  Parents & caretaker relatives
  42 CFR §435.110

  Pregnant Women
  42 CFR §435.116

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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

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

(*select one*):

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

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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:

Integrated Care Organizations (ICOs) conduct the evaluations for all Nursing Facility Level of Care Determinations (NFLOCDs).

- ( ) **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:

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health care professional. MI Health Link has more stringent criteria as defined in the 3 way contract with CMS and ICOs which includes: A Michigan licensed registered nurse, nurse practitioner, physician’s assistant, or Bachelor’s or Master’s prepared limited licenses or licensed social worker or clinical nurse specialist employed or contracted with the ICO who is accountable for providing Care Coordination services and trained in person-centered planning techniques.

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.

Enrollment into the MI Health Link waiver requires the applicant to meet the specified medical/functional eligibility criteria for nursing facility level of care as identified in Michigan NFLOCD policy.The NFLOCD tool is an online form/template which is completed either electronically or in hard copy form and maintained in the enrollee's record.Electronic or hard copy NFLOCDs may be completed to establish ongoing eligibility.The applicant must meet,and continue to meet,the NFLOCD criteria on an on-going basis to remain eligible for the program.Nursing facility level of care criteria consists of eight medical/functional domains that are outlined in the Michigan Medicaid Nursing Facility Level of Care Determination(LOCD).

Door 1 - Activities of Daily Living (ADL) Dependency
Self-ability in (A) Bed (sleeping surface) Mobility, (B) Transfers, and (C) Toilet Use in the last seven (7) calendar days from the date the LOCD was conducted:

_ Independent or Supervision = 1
_ Limited Assistance = 3
_ Extensive Assistance or Total Dependence = 4
_ Activity Did Not Occur during the entire 7-day period regardless of ability (applicant was not mobile, did not transfer, did not toilet) = 8

Self-ability in (D) Eating in the last seven calendar days from the date the LOCD was conducted:
_ Independent or Supervision = 1
_ Limited Assistance = 2
_ Extensive Assistance or Total Dependence = 3
_ Activity Did Not Occur during the entire 7-day period regardless of ability (applicant did not eat) = 8
The applicant must score at least six points in Door 1 to qualify.

Door 2 - Cognitive Performance

The Cognitive Performance Scale is used to identify cognitive difficulties with short-term memory and daily decision-making.
A. Short Term Memory: determine the applicant’s functional capacity to remember recent events (i.e., short term memory).

_ Memory Okay is selected when applicant appears to recall after five (5) minutes.
_ Memory Problem is selected when the applicant does not recall after five (5) minutes.

B. Cognitive Skills for Daily Decision Making. Review events of the last seven (7) calendar days from the date the LOCD was conducted and score how the applicant made decisions regarding tasks of daily life.

_ Independent: decisions were consistent, reasonable; applicant organized daily routine consistently and reasonably in an organized fashion.
_ Modified Independent: applicant organized daily routines, made safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations.
_ Moderately Impaired: applicant’s decisions were poor, required reminders, cues and supervision in planning, organizing and correcting daily routines.
_ Severely Impaired: applicant’s decision-making was severely impaired;
_ Applicant never or rarely made decisions.

C. Making Self Understood. Within the last seven (7) calendar days from the date the LOCD was conducted, document the applicant’s ability to express or communicate requests, needs, opinions, urgent problems and social conversation.

_ Understood: applicant expresses ideas clearly and without difficulty.
_ Usually Understood: applicant has difficulty finding the right words or finishing thoughts, resulting in delayed responses; little or no prompting is required.
_ Sometimes Understood: applicant has limited ability, but is able to express concrete requests regarding basic needs (food, drink, sleep, toilet).
_ Rarely/Never Understood: at best, understanding is limited to interpretation of highly individual, applicantspecific sounds or body language.

The applicant must score under one of the following three options to qualify for Door 2:

1. ‘Severely Impaired‘ in Decision Making.
2. ‘Yes’ for Memory Problem, and Decision Making is ‘Moderately Impaired’ or ‘Severely Impaired.’
3. ‘Yes’ for Memory Problem, and Making Self Understood is ‘Sometimes Understood’ or ‘Rarely/Never Understood.’

Door 3 - Physician Involvement

The number of days in which the physician or authorized assistant/practitioner examined the applicant or changed orders in the last 14 calendar days from the date the LOCD was conducted.

A. Physician Visits/Exams: in the last 14 calendar days, count the number of days the applicant was examined. For example, if three physicians examined the applicant on the same day over the last 14 calendar days, count that as one exam. Do not count emergency room examinations. Do not count visits/exams made while the applicant was hospitalized. Do not count examinations prior to the last 14 calendar days.
B. Physician Orders: in the last 14 calendar days, count the number of days the physician changed the applicant’s orders. For example, if three physicians changed orders on the same day over the last 14 calendar days, count that as one order change. Do not count drug or treatment order renewals without change. Do not count sliding-scale order changes. Do not count emergency room orders. Do not count orders prior to the last 14 calendar days.

The applicant must meet the following criteria to qualify for Door 3:
1. Over the last 14 calendar days, at least one day in which the Physician visited and examined the applicant AND at least four days in which the Physician changed orders, OR
2. Over the last 14 calendar days, at least two days in which the Physician visited and examined the applicant AND at least two days in which the Physician changed orders.

Door 4 - Treatments and Conditions
Nine Treatments/Conditions require a physician-documented diagnosis in the medical record. The treatments/conditions must be evidenced within the last fourteen (14) calendar days from the date the LOCD was conducted. Applicants will no longer qualify under the treatment/condition once it has been resolved OR no longer affects functioning OR no longer requires the need for care. Applicants who are determined eligible require ongoing assessment and follow-up monitoring. Care planning and the focus for treatment for these applicants must involve active restorative nursing and discharge planning.

Treatment/Condition: Stage 3-4 pressure sores; Intravenous or Parenteral Feedings; Intravenous Medications, End stage care; Daily Tracheostomy care, Daily Respiratory care, Daily Suctioning; Pneumonia within the last 14 days; Daily Oxygen Therapy (not Per Resident Need); Daily insulin with two order changes in last 14 days; Peritoneal or Hemodialysis.

The applicant must score ‘Yes’ in at least one of the nine categories AND have a
continuing need to qualify for Door 4.

Door 5 - Skilled Rehabilitation Therapies
Skilled rehabilitation interventions is based on ordered AND scheduled therapy services within the last 7 calendar days from the date the LOCD was conducted.

A. Speech Therapy in the last seven calendar days
B. Occupational Therapy in the last seven calendar days
C. Physical Therapy in the last seven calendar days

_ Minutes: record the total minutes speech, occupational and physical therapy was administered for at least 15 minutes a day. Do not include evaluation minutes. Zero minutes are recorded if less than 15.
_ Scheduled Therapies: record the estimated total number of speech, occupational and physical therapy minutes the applicant was scheduled for, but did not receive. Do not include evaluation minutes in the estimation. Zero minutes are recorded if less than 15.

The applicant must have required at least 45 minutes of active speech therapy, occupational therapy, or physical therapy (scheduled or delivered) in the last seven calendar days AND continue to require skilled rehabilitation therapies to qualify for Door 5.

Door 6 – Behavior
The repetitive display of behavioral challenges, OR the experience of delusions or hallucinations, both of which are supported by the Preadmission Screen Annual Resident Review (PASARR) requirement for nursing facility admission if the applicant chooses a residential setting for care, that impact the applicant's ability to live independently in the community and are identified in Door 6. Behavioral challenges, hallucinations and delusions must have occurred within seven (7) calendar days prior to the date the LOCD was conducted online. The
challenging behaviors are:

1. Wandering: moving about with no discernible, rational purpose; oblivious to physical or safety needs.
2. Verbal Abuse: threatening, screaming at or cursing at others.
3. Physical Abuse: hitting, shoving, scratching or sexually abusing others.
4. Socially Inappropriate/Disruptive: disruptive sounds, noisiness, screaming, performing self-abusive acts, inappropriate sexual behavior or disrobing in public, smearing or throwing food or feces, or hoarding or rummaging through others' belongings.
5. Resists Care: verbal or physical resistance of care (i.e., physically refusing care, pushing caregiver away, scratching caregiver). This category does not include the applicants informed choice to not follow a course of care or the right to refuse treatment; do not include episodes where the applicant reacts negatively as others try to re-institute treatment that the applicant has the right to refuse.

The applicant must have exhibited any one of the above behavioral symptoms in at least four of the last seven calendar days (including daily) from the date the LOCD was conducted OR the applicant exhibited delusional thinking or clearly demonstrated having experienced hallucinations within seven calendar days from the date the LOCD was conducted AND met the PASARR requirement for nursing facility admission if they choose a residential setting of care to qualify for Door 6.

Door 7 - Service Dependency
Service dependency applies to current beneficiaries only who are enrolled in and receiving services from a Medicaid-certified nursing facility, MI Choice program or the Program of All Inclusive Care for the Elderly (PACE), or the MI Health Link HCBS waiver. All three of the following criteria must be met to demonstrate service dependency:

1. Applicant has been served by a Medicaid reimbursed nursing facility, MI Choice, PACE, or MI Health Link HCBS waiver for at least one year; consecutive time across the programs (no break in service) may be combined
AND
2. Applicant requires ongoing services to maintain current functional status
AND
3. No other community, residential or informal services are available to meet the applicant's needs (only the current provider can provide those services/needs)

The applicant must meet all three of the above criteria to be determined service dependent to qualify for Door 7.

Door 8- Frailty Criteria; an applicant need trigger only one element from the frailty, behaviors, or treatment categories below.

The applicant has a significant level of frailty as demonstrated by at least one of the following categories:
-Applicant performs late loss ADLs (bed mobility, toileting, transferring, or eating independently but requires an unreasonable amount of time.
-Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.
-Applicant has experiences at least two falls in the home in the past month.
-Applicant continues to have difficulties managing medications despite the receipt of medication set-up services.
-Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services.
-Applicant meets criteria for Door 3 when emergency room visits for clearly unstable conditions are considered.

Behaviors:
The applicant has at least a one month history of any of the following behaviors, and has exhibited two or more of any of these behaviors in the last seven days, either singly or in combination:
-wandering
-verbal or physical abuse
-socially inappropriate behavior
-resists care

Treatments:
The applicant has demonstrated a need for complex treatments or nursing care.

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

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

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

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

The NFLOCD must be conducted and entered in CHAMPS within 14 days from learning about the individual's potential need for waiver services in either the electronic or paper format of the NFLOCD tool. Annual NFLOCD reevaluations are conducted by ICO Care Coordinators and MDHHS. The ICO Care Coordinator must document the NFLOCD outcome in the case record. The electronic and paper versions of the NFLOCD are the same assessment requiring the same eligibility criteria. The NFLOCD tool must be submitted to MDHHS for approval.The LOCD is required to be conducted every 365 days or sooner if there is a significant change in condition. MDHHS or MDHHS's online NFLOC/LOCD system determines whether the applicant/participant meets or does not meet nursing facility level of care. Any LOCD that does not meet eligibility requirements is reviewed by MDHHS. MDHHS provides advanced notice and information on appeal rights when applicable.

The criteria is the same for evaluations and reevaluations.

The LOCD assessment is comprised of several different "doors" which are different medical/functional conditions or categories through which an individual may meet LOCD. ICOs are responsible for conducting the assessments and gathering the appropriate information to support the Door through which they think the individual may meet. The criteria are selected in the CHAMPS LOCD system, and CHAMPS makes the level of care determination. A random sample of the records in CHAMPS is pulled for MDHHS review, at which time the ICO that conducted the assessment must submit supporting documentation to MDHHS for review and approval.

MDHHS uses a two-tiered quality assurance strategy to verify the quality of all level of care determinations conducted within the state. The first tier is a statewide process used for nursing facilities, MI Health Link, PACE, and MI Choice. MDHHS requires ALL nursing facility level of care determinations conducted for individuals who are either applying or currently served by a long-term care program to be put in a secure web-based system that is located within the Community Health Automated Medicaid Payments System (CHAMPS), Michigan's Medicaid Management Information System. Licensed, qualified health professionals conduct the nursing facility level of care determination using the statewide tool (available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-103102--,00.html) and input their findings into the software application within CHAMPS. CHAMPS then runs the data through the nursing facility level of care algorithm to determine whether an individual meets the nursing facility level of care.

The quality assurance for this first tier is to randomly select at least 400 records that meet the nursing facility level of care and 400 records that do not meet the nursing facility level of care for additional review. MDHHS contracts with the Michigan Peer Review Organization (MPRO) to conduct reviews of the selected records to verify the level of care determination was properly conducted by the health professional. 100% of LOCDs for MI Health Link Beneficiaries that do not meet the nursing facility level of care are reviewed by MDHHS. MDHHS provides advanced action notice and information on appeal rights when applicable.

Because the number of level of care determinations that are conducted per year will vary, MDHHS applied the following formula for determining a statistically significant sample size of an unknown population:
Necessary Sample Size = (Z-score)2 * StdDev*(1-StdDev) / (margin of error)2
Where: Margin of Error equals 95%
Z-score equals 1.96 (95% confidence)
Standard Deviation (StdDev) equals .5
((1.96)2 * .5(.5)) / (.05)2 = 384.16, or 385 if rounding up.

Therefore, the minimum number of cases that should be reviewed on ALL level of care determinations statewide only needs to be 385. MDHHS rounded that number up to 400 to assure the sample size remains statistically significant. Additionally, because of the adverse effects to the beneficiary of improperly determining that they do not meet the nursing facility level of care, MDHHS felt it important to assure that we are reviewing a statistically significant sample of both eligible and non-eligible determinations. Therefore, MDHHS will be reviewing at least 800 level of care determinations each year, 400 that meet level of care criteria, and 400 that do not meet level of care criteria.

For this first tier of quality assurance, MDHHS uses the simple random sampling technique. This technique is needed for several reasons. First, the nursing facility level of care determination is required to be completed BEFORE the individual is enrolled in a HCBS program. Second, individuals often require this determination BEFORE they can become eligible for Medicaid-funded LTSS. Lastly, individuals commonly transfer between HCBS programs and nursing facilities. Therefore, stratification of this sample based upon the program utilized by the individual at the time of the determination

is impossible.

The second tier of quality assurance for the MI Health Link program is the Clinical Quality Assurance Review process. This process randomly selects a statistically significant sample of MI Health Link case records to review. The population includes participants who have been enrolled in MI Health Link for at least 90 days in the review year. The process for making this selection is to use an online sample size calculator, using 95% confidence level and a standard deviation of .5. Once the sample size is determined, the clinical reviewer uses the probability proportional to size (PPS) sampling method to determine the number of records to review from each ICO. This is employed by determining the percentage of the MI Health Link population served by each ICO, then applying that percentage to the number of records required for a statistically significant result. For example, if the total number of records to review was 300, and an ICO served 10% of the total statewide participants, that agency would have 30 records reviewed. The specific records reviewed for each agency are randomly selected using the systemic sampling method.

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:

A reevaluation is required every twelve months or sooner if there is a significant change in condition.

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):*

As required by the state, ICO Care Coordinators or other designated supports coordinators will reevaluate each MI Health Link HCBS enrollee's level of care at each in person reassessment visit. The ICO Care Coordinators or other designated supports coordinators document that the enrollee continues to meet the nursing facility level of care within the case record, usually specifying the appropriate "Door" through which the enrollee meets level of care criteria. Reassessments are conducted in person annually or upon a significant change in the enrollee's condition. ICO Care Coordinators or other designated supports coordinators track reassessment dates within the ICOs' information systems. If an ICO Care Coordinator or other designated supports coordinator suspects the enrollee no longer meets the nursing facility level of care, the ICO Care Coordinator completes another LOCD and enters the information in the State's NFLOC/LOCD system, which makes the level of care eligibility determination. When the system or MDHHS confirms the enrollee no longer meets nursing facility level of care, program discharge procedures are initiated and MDHHS provides the enrollee with advanced notice and information on appeal rights.

The clinical reviewers monitor compliance to this requirement during the clinical quality assurance reviews.

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:

Paper copies of level of care determinations for enrollees are maintained by the ICO for a minimum period of ten years. This information is also maintained in the MDHHS LOCD database for a minimum of seven years.

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 new MI Health Link HCBS waiver enrollees who meet the NFLOC criteria prior to the receipt of waiver services. Numerator: Number of MI Health Link HCBS waiver enrollees who meet the NFLOC criteria prior to the receipt of waiver services. Denominator: All new MI Health Link HCBS waiver enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
online database, other documents submitted to MDHHS, 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 =
☒ **Other** Specify: ICOs	☐ **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.

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 level of care determinations made by a qualified evaluator.
Numerator: Number of level of care determinations made by a qualified evaluator.
Denominator: All level of care determination files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CHAMPS, online database, off-site record reviews

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 =

		Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☐ **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.

1) MDHHS has qualified reviewers to conduct case record reviews on a sample of cases to compare level of care determinations (LOCDs) with actual assessments. Qualified reviewers analyze findings and verify that enrolled individuals are eligible, LOCD items match comparable assessment responses, and care coordinators reevaluate enrollees annually. MDHHS staff compiles results into the final written review report provided to the ICO. When qualified reviewers identify non-compliance, immediate remediation is required and pursued. Additionally, qualified reviewers may provide instructions for assuring compliance and MDHHS staff provides training as needed.
2) MDHHS or its designee conducts reviews to validate the LOCD as performed by the entity conducting the NFLOCDs. The ICO must submit all supporting documentation requested by MDHHS or its designee.
3) MDHHS uses an edit process within the Medicaid Management Information System (MMIS)(Community Health Automated Medicaid Processing System (CHAMPS)) to prohibit generation of a tier 2 capitation payment for enrollees who do not have a valid NFLOCD.
4) MDHHS reviews NFLOCD appeal and decision summaries regularly, provides technical assistance and training, and initiates corrective actions as needed.
5) MDHHS policy requires each ICO to use the established NFLOCD process and forms. ICOs have first line responsibility for ensuring on a continual basis that ICO Care Coordinators or LTSS Supports Coordinators determine enrollees eligible by using this process and MDHHS requires them to monitor determinations for errors and omissions. MDHHS requires the ICOs to have written procedures that follow MDHHS policy. As part of the review process, MDHHS or its designee ensures that the ICO uses the NFLOCD process and instruments described in this waiver application to determine level of care.
6) The new strategy for reviewing LOCDs will be in addition to the existing quality assurance and monitoring efforts. It provides additional program integrity. The statistically significant random sample for the new LOCD review process will be a different sample from that pulled for the clinical quality assurance review for the existing quality assurance process, though some cases may overlap based on the nature of a random sample.

7) As part of the clinical quality assurance review conducted by the EQRO, a statistically significant random sample of MI Health Link participants is reviewed for accuracy of the LOCDs conducted and whether the individual meets ongoing program eligibility. The LOCD record is compared to other clinical documentation such as assessments, physician orders, etc., in the participant's record to ensure the information is consistent. The MDHHS designee will review a statistically significant random sample of all LOCDs entered into the CHAMPS system for all LTSS programs including nursing facilities, MI Choice Waiver, PACE, and MI Health Link HCBS Waiver. The random sample calculator website by Raosoft is used to determine an appropriate statistically significant random sample. For the review, providers will submit documentation supporting the criteria they entered in CHAMPS from which CHAMPS made the level of care determination.

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.

During reviews to validate the LOCD, if an applicant is found to be ineligible for the nursing facility level of care, the ICO must help the enrollee find alternative services in the community. Then the enrollee must be disenrolled from the MI Health Link HCBS waiver and given their appeals rights. MDHHS will recover all Medicaid capitation payments made during the period of ineligibility. NFLOCDs resulting from such reviews may be appealed by the ICO through procedures established by MDHHS.
If during the quality assurance review process, any waiver enrollee is found to not have an eligibility redetermination within 12 months of the enrollee's last evaluation, the ICO must conduct a level of care evaluation within two weeks of notification of finding, if one has not already been conducted.

During the reviews, if any NFLOCDs were incorrectly applied, the ICO must conduct a new NFLOCD within two weeks of notification of finding. If the enrollee originally was found ineligible for the waiver program, but the NFLOCD finds the enrollee eligible, the enrollee must be enrolled with the program as soon as possible. If the NFLOCD was done incorrectly but eligibility does not change, the ICO must ensure another NFLOC is conducted by the assessing entity.
If during the quality assurance review, any level of care determinations are found to be conducted by someone unqualified, the ICO must conduct a new NFLOCD by someone who is a qualified evaluator. If a new NFLOCD is performed by a qualified evaluator and an enrollee is found to be ineligible for MI Health Link HCBS, MDHHS shall disenroll the enrollee from the waiver, offer them appeal rights, and recover all Medicaid capitation payments made during the period of ineligibility. MDHHS will pay ICOs the correct capitation payment if the individual is still eligible for other physical health services offered through MI Health Link.

After completing the quality assurance reviews, MDHHS conducts exit conference with the ICO staff. During the exit conference, the ICO is provided with a summary report of findings including any findings that require immediate remediation. The immediate remediation is due within 72 hours. MDHHS also compiles quality assurance review findings from annual audits, critical incident reviews and provider monitoring reviews into draft reports that are sent to the ICO. The ICO will receive a rebuttal period of 5 business days in which they can submit documentation not previously reviewed to support reconsideration of findings. MDHHS will make any revisions to the draft reports as appropriate and the ICO will receive a final report. When the final report indicates a need for corrective action, the ICO has 30 calendar days to respond with a corrective action plan (CAP) utilizing MDHHS template.
Corrective action plans should demonstrate that the ICO has:
1.Analyzed all non-evident findings and determined possible causes;
2.Developed a remediation strategy, including timelines, that address and resolve the problems; and
3.Planned ongoing monitoring of remediation activities and performance.
MDHHS will review the CAP and will accept or request a resubmission. If accepted, the plan will have 90 calendar days to implement. If a resubmission is requested, the plan will be required to update the CAP and resubmit within 7 calendar days. After second submission, if the CAP is not accepted, MDHHS will execute sanctions in accordance with the Three Way Contract until a submitted CAP is accepted. MDHHS may request an independent validation audit in accordance with MDHHS and CMS requirements.
MDHHS will monitor the implementation of the CAP. ICOs are required to provide evidence of their remediation strategy by submitting documentation to MDHHS following the implementation phase utilizing MDHHS template. This documentation might include training materials, revised policies and procedures, information from staff meetings or case record documentation to support the corrective action plan has been implemented. Ongoing monitoring will occur as needed.

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):*
ICOs	
	☒ **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).

Any individual applying for Medicaid long term supports and services (LTSS, including nursing facility services, MI Choice, MI Health Link HCBS or PACE) must meet functional eligibility through the Michigan Medicaid Nursing Facility Level of Care. Once an applicant has qualified for services under the nursing facility level of care criteria, the applicant must be informed of benefit options and elect, in writing, to receive services in a specific program. This election must take place before initiating Medicaid funded LTSS in the specified program.

Upon meeting the nursing facility level of care, the applicant or legal representative, must be informed of the following available services. Services available in a community setting include MI Health Link HCBS, MI Choice, PACE, Home Health, State Plan Personal Care Services, or nursing facility institutional care.

If applicants are interested in community-based care, but currently reside in a nursing facility, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDHHS website at www.michigan.gov/mdhhs. Applicants who prefer a community long term care option, but are admitted to a nursing facility because of unavailable capacity or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must indicate their choice of program in writing by signing the freedom of choice (FOC) form. A completed copy of this form must be retained in the applicant's case record for ten years. The FOC form must also be witnessed by an applicant’s representative when available. MDHHS ensures that ICOs inform participants that have a right to choose LTSS through the verification review of NFLOCDs, which is conducted through a peer review organization under contract with the State. The peer review organization and qualified reviewers verify that ICOs have signed FOC forms in the enrollee’s records indicating that choice has been offered and discussed.

Applicants or their legal representative are required to sign and date the MI Health Link HCBS Application Form, indicating they have chosen to participate in the MI Health Link HCBS waiver and have been offered a choice of services and providers. The ICO must submit this signed form to MDHHS along with the rest of the required documents for the MI Health Link HCBS application.

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.

The FOC form must be signed and dated by the applicant seeking services or their legal representative, indicate the participant's preference for MI Health Link HCBS, completed according to established policies and procedures, and must be maintained in the applicant's case record at the ICO.

Applicants or their legal representative are required to sign and date the MI Health Link HCBS Application Form, indicating they have chosen to participate in the MI Health Link HCBS waiver and have been offered a choice of services and providers. The ICO must submit this signed form to MDHHS along with the rest of the required documents for the MI Health Link HCBS application. ICOs are required to keep this form in the applicant's file. MDHHS also retains the signed form along with the application packet.

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):

ICOs are required to provide information in a culturally sensitive manner to all applicants and enrollees. Depending on the local community and the 5% langauge translation requirement, brochures may be provided in non-English languages. Oral translation services are available to all who request them.

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	**Adult Day Program**		
Statutory Service	**Respite**		
Extended State Plan Service	**Adaptive Medical Equipment and Supplies**		
Supports for Participant Direction	**Fiscal Intermediary**		
Other Service	**Assistive Technology**		
Other Service	**Chore Services**		
Other Service	**Community Transition Services (terminated effective 04/24/2019)**		
Other Service	**Environmental Modifications**		
Other Service	**Expanded Community Living Supports**		
Other Service	**Home Delivered Meals**		
Other Service	**Non-Medical Transportation**		
Other Service	**Personal Emergency Response System**		
Other Service	**Preventive Nursing Services**		
Other Service	**Private Duty Nursing**		

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:

Adult Day Health

Alternate Service Title (if any):

Adult Day Program

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the enrollee. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Transportation between the enrollee's residence and the Adult Day Program center is provided when it is a standard component of the service. Not all Adult Day Program centers offer transportation to and from their location. Adult Day Program centers that do offer transportation may only offer it in a specified area. When the Adult Day Program Center offers transportation, it is a component part of the Adult Day Program service. If the center does not offer transportation, then the ICOs would pay for the transportation to and from the Adult Day Program center separately through MI Health Link c-waiver funds.

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

Enrollees cannot receive Community Living Supports or Expanded Community Living Supports during the time spent at the Adult Day Program facility. Payment for Adult Day Program includes all services provided while at the facility.

Adult Day Program should only be authorized if the enrollee meets at least one of the following criteria:
- Requires regular supervision to live in his or her own home or the home of a relative
- If he or she has a caregiver, the enrollee must require a substitute caregiver while his or her regular caregiver is unavailable
- Has difficulty or is unable to perform activities of daily living without assistance
- Capable of leaving his or her residence with assistance to receive services
- In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization

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	Adult Day Program Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Program

Provider Category:
Agency
Provider Type:

Adult Day Program Agency

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person for every ten enrollees. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.

2. The provider shall require staff to participate in orientation training as specified in the operating standards document(s) which will be provided to ICOs. Additionally, program staff shall have basic first-aid training. The provider shall require staff to attend in-service training at least twice each year. The provider shall design this training specifically to increase their knowledge and understanding of the program and enrollees, and to improve their skills at tasks performed in the provision of service. The provider shall maintain records that identify the dates of training, topics covered, and persons attending.

3. If the provider operates its own vehicles for transporting enrollees to and from the program site, the provider shall meet the following transportation minimum standards:
a. All drivers must be properly licensed, and all vehicles registered, by the Michigan Secretary of State. All vehicles shall be appropriately insured.
b. All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
c. All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
d. Each agency and transportation entity must be in compliance with Public Act 1 of 1985 regarding seat belt usage.

4. Each provider shall have first-aid supplies available at the program site. The provider shall make a staff person knowledgeable in first-aid procedures, including CPR, present at all times when enrollees are at the program site.

5. Each provider shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.

6. Each day program center shall have the following furnishings:
a. At least one straight back or sturdy folding chair for each enrollee and staff person.
b. Lounge chairs or day beds as needed for naps and rest periods.
c. Storage space for enrollees' personal belongings.
d. Tables for both ambulatory and non-ambulatory enrollees.
e. A telephone accessible to all enrollees.
f. Special equipment as needed to assist persons with disabilities.

The provider shall maintain all equipment and furnishings used during program activities or by program enrollees in safe and functional condition.

7. Each day program center shall document that it is in compliance with:
a. Barrier-free design specification of the State of Michigan and local building codes.
b. Fire safety standards.
c. Applicable State of Michigan and local public health codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and 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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite care services are provided on a short-term, intermittent basis to relieve the enrollee's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.

Respite services may be provided in the enrollee's home, in the home of another, in licensed Adult Foster Care or Home for the Aged facilities, nursing facilities that are Medicaid certified, or other State-approved facilities.
- Respite does not include the cost of room and board in instances when the service is provided in the enrollee's home or in the home of another person.
- Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged, nursing facility, or other State-approved facility.
-Respite services inlcude:
a. Attendant care (enrollee is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
b. Basic care (enrollee may or may not be bed-bound) such as assistance with ADLs, a routine excercise regimen, and self-medication.

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

- Respite services cannot be scheduled on a daily basis except in situations that involve the regular unpaid caregiver's absence/vacation, or if the respite is provided in a facility on a temporary basis.
- Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers
- Respite services shall not be provided by the enrollee's usual caregiver who provides other waiver services to the enrollee

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	Facility
Individual	Individuals chosen by the enrollee who meet qualification standards
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility

Provider Qualifications

License *(specify):*

Nursing facilities: sections 2226(d), 2233, 20115, 20145, 20171, 21741, and 21795 of 1978 PA 368, MCL 333.2226(d), 333.2233, 333.20115, 333.20145, 333.20171, 333.21741, and 333.21795; section 9 of 1965 PA 380, MCL 16.109.

Administrative Rules 325.20101-325-22004.

Certificate *(specify):*

Must meet any applicable federal laws or rules for certification and/or licensure.

Other Standard *(specify):*

Other State-approved facilities that meet specific needs of Waiver enrollees.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to service delivery and annually 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:

Individuals chosen by the enrollee who meet qualification standards

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The enrollee's records should include a clear distinction of when Respite is provided instead of Chore Services and Expanded Community Living Supports.

2. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

3. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, be able to follow instructions, able to perform basic first aid procedures, in good standing with the law, and trained in the enrollee's Individual Integrated Care and Supports Plan (IICSP), as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to delivery of service and annually 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:

Home Care Agency

Provider Qualifications

License *(specify):*

Adult Foster Care: Act 218 of 1979; Homes for the Aged: MCL 333.21311; If respite is provided by a home care agency nurse, either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN, the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211.

Certificate *(specify):*

Other Standard *(specify):*

When providing care in the home of the enrollee:

1. The enrollee's records should include a clear distinction of when Respite is provided instead of Chore Services and Expanded Community Living Supports.

2. Each direct service provider shall establish written procedures that govern the assistance given by staff to enrollees with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall include, at a minimum:

a. The provider staff authorized to assist enrollees with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the enrollee takes and its impact upon the enrollee.

b. Verification of prescription medications and their dosages.

c. Instructions for entering medication information in participant files.

d. A clear statement of the enrollees and responsibilities of the enrollee's family member(s) regarding medications taken by the enrollee and the provision for informing the enrollee and the enrollee's family of the provider's procedures and responsibilities regarding assisted self administration of medications.

3. Each direct service provider shall employ a professionally qualified supervisor that is available to staff while staff provide respite.

When providing respite in a licensed setting:

1. Each out of home respite service provider must be a licensed group home as defined in MCL 400.701ff, which includes adult foster care homes and homes for the aged.

2. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.

3. Each direct service provider shall demonstrate a working relationship with a hospital or other health care facility for the provision of emergency health care services, as needed. With the assistance of the enrollee or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to delivery of service and 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:

Extended State Plan Service

Service Title:

Adaptive Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Devices, controls, or appliances specified in the IICSP that enable enrollees to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid state plan and Medicare that are necessary to address enrollee functional limitations. All items shall meet applicable standards of manufacture, design, and installation. This will also cover the costs of maintenance and upkeep of equipment. The coverage includes training the enrollee or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.

Some examples (not an exhaustive list) of these items would be shower chairs/benches, lift chairs, raised toilet seats, reachers, jar openers, transfer seats, bath lifts/room lifts, swivel discs, bath aids such as long handle scrubbers, telephone aids, automated telephones or watches that assist with medication reminders, button hooks or zipper pulls, modified eating utensils, modified oral hygiene aids, modified grooming tools, heating pads, sharps containers, exercise items and other therapy items, voice output blood pressure monitor, nutritional supplements such as Ensure, specialized turner or pointer, mouthstick for TDD, foot massaging unit, talking timepiece, adaptive eating or drinking device, book holder, medical alert bracelet, adapted mirror, weighted blanket, and back knobber.

It must be documented on the IICSP or case record that the item is the most cost-effective alternative to meeting the enrollee’s needs.

Items must meet applicable standards of manufacture, design, and installation.

There must be documentation on the IICSP or case record that the best value in warranty coverage was obtained at the time of purchase.

Items must be of direct medical or physical benefit to the enrollee.

Items may be purchased directly from retail stores that offer the item to the general public.

Liquid nutritional supplement orders must be renewed every six months by a physician, physician’s assistant, or nurse practitioner (in accordance with scope of practice).

This service does not include herbal remedies, nutraceuticals, or over-the-counter items not approved by the FDA.

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

Items covered by the MI Health Link c-waiver shall be in addition to any medical equipment and supplies covered under the Michigan Medicaid State Plan and shall exclude those items that are not of direct medical or remedial benefit to the enrollee.

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	Retail Store
Agency	Enrolled Medicaid or Medicare DME Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adaptive Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Retail Store

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Items purchased from retail stores must meet the Adaptive Medical Equipment and Supplies service definition. ICOs must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adaptive Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:

Enrolled Medicaid or Medicare DME Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Each direct service provider must enroll in Medicare and Medicaid as a Durable Medical Equipment/POS provider or pharmacy, as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and 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:
Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Fiscal Intermediary

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Fiscal Intermediary (FI) services assist the enrollee, or a representative identified in the enrollee's Integrated Care and Supports Plan (IICSP) to live independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The FI helps the enrollee to manage and distribute funds contained in the individual budget. The enrollee uses funds to purchase home and community based services authorized in the IICSP.

FI services include, but are not limited to, the facilitation of the employment of service workers by the enrollee, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring enrollee-directed budget expenditures and identify potential over and under expenditures; assuring compliance with documentation requirements related to management of public funds. The FI helps the enrollee manage and distribute funds contained in the individual budget. The FI also assists with training the enrollee and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

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

Fiscal Intermediary services are available only to enrollees participating in arrangements that support self-determination. Additionally, Fiscal Intermediary services may not be provided by providers of other services to the enrollee, or his or her family or guardians.

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	Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Provider must be bonded and insured for an amount that meets or exceeds the total budgetary amount the fiscal intermediary is responsible for administering. The provider must have 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. Fiscal Intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Providers of other covered services to the enrollee, the family or guardians of the enrollee may not provide Fiscal Intermediary services to the enrollee. Fiscal Intermediary service providers must pass a readiness review and meet all criteria sanctioned by the state. Fiscal intermediaries will comply with all requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of services and 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:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This includes technology items used to increase, maintain, or improve an enrollee's functioning and promote independence. The service may include assisting the enrollee in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the enrollee's primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the enrollee and specified under the IICSP.

Some examples include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener, specialized alarm or intercom.

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

- Items like cell phones, internet service, full-home wiring systems would be excluded from this benefit.
- This does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.
- It must be documented that the item is the most cost-effective alternative to meeting the enrollee's needs.
- Items must meet applicable standards of manufacture, design, and installation.
- There must be documentation that the best value in warranty coverage was obtained at the time of purchase.
- Items must be of direct medical or physical benefit to the enrollee.
- As applicable, items may be purchased directly from retail stores that offer the item to the general public.
- $15,000 maximum for van lifts, including tie downs, for the duration of the 5-year waiver period.
- $5000 yearly (waiver year) maximum for all other assistive technology devices
- Modifications will only be made to vehicles with proper insurance coverage, with the exception of new vehicles coming directly from an automotive factory to the entity performing the modification.

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	Other Contracted or Subcontracted Provider
Agency	Retailers
Agency	Enrolled Medicaid or Medicare DME Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Other Contracted or Subcontracted Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The contracted/subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the ICOs. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:

Retailers
Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Items purchased from retail stores must meet the Assistive Technology service definition. ICOs must be prudent with their purchases and may have a business account with the retail store.
Verification of Provider Qualifications
Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:

Enrolled Medicaid or Medicare DME Provider
Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Each direct service provider must enroll in Medicare and Medicaid as a Durable Medical Equipment/POS provider or pharmacy, as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and 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:

Chore Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, and cleaning hazardous debris such as fallen branches and trees. May include materials and disposable supplies used to complete chore tasks.

Pest control suppliers must be properly licensed.

Chore services are allowed only in cases when neither the enrollee nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Specify applicable (if any) limits on the amount, frequency, or duration of 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
Individual	Individuals chosen by the enrollee
Agency	Contracted or subcontracted provider other than an individual chosen by the enrollee

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Individual
Provider Type:

Individuals chosen by the enrollee

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be able to prevent transmission of communicable disease (as applicable for job duties), and be in good standing with the law as validated by a criminal history review conducted by the ICO.

2. Previous relevant experience and training to meet MDHHS operating standards.

3. Must be deemed capable of performing the required tasks by the ICO.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and annually therafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Contracted or subcontracted provider other than an individual chosen by the enrollee

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Only properly licensed suppliers may provide pest control services. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.

2. Each ICO must develop working relationships with the Home Repair and Weatherization service providers, as available, in their program area to ensure effective coordination of efforts.

3. Ability to communicate effectively both verbally and in writing as well as to follow instructions.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and 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:

Community Transition Services (terminated effective 04/24/2019)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service was terminated as a waiver service effective 4/24/19 as it became a state plan covered service. Beneficiaries will not be impacted as they will continue to receive the service from the ICO. The ICO will be reimbursed in their rates for the service as a state plan covered service.

This service includes non-reoccurring expenses for enrollees transitioning from a nursing facility to another residence where the enrollee is responsible for his or her own living arrangement. Allowable transition costs include the following: - Housing or security deposits; A one-time expense to secure housing or obtain a lease. - Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are excluded). - Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded). - Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning. - Coordination and support services: To facilitate transitioning of enrollee to a community setting. - Other: Services deemed necessary and documented within the enrollee's plan of service to accomplish the transition into a community setting. Costs for Community Transition Services are billable upon enrollment into the MI Health Link HCBS waiver.

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

- Excludes ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes
- If home modifications are needed, only those which are immediately necessary for community transition shall be authorized as Community Transition Services. Otherwise, they should be provided as an environmental modification.
- Community Transition Services shall begin no more than six months prior to expected discharge from a nursing facility - Within 15 days of the date of transition to the community, all Community Transition Services items should be identified and documented in the transition plan
- The timeframes associated with this service may be extended in unique circumstances that require additional support and coordination efforts

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	Contracted Provider Other Than Retail Store
Agency	Retail Store

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (terminated effective 04/24/2019)

Provider Category:

Agency

Provider Type:

Contracted Provider Other Than Retail Store

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The contracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDCH and the ICOs. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services (terminated effective 04/24/2019)

Provider Category:

Agency

Provider Type:

Retail Store

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Items purchased from retail stores must meet the Community Transition Services definition. ICOs must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to delivery of services and 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:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical adaptations to the home, required by the enrollee's service plan, that are necessary to ensure the health and welfare of the enrollee or that enable the enrollee to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the enrollee. Complex kitchen and bathroom modifications may be completed if medically necessary for the enrollee. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence.

The case record must contain documented evidence that the modification is the most cost effective and reasonable alternative to meet the enrollee's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing.

The enrollee, with the direct assistance of the care coordinator/LTSS coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA) and community development block grants. The enrollee's record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. The MHL waiver is a funding source of last resort.

The ICO must assure that there is a signed contract or bid proposal with the builder or contractor prior to the start of an environmental modification. Is is the responsibility of the ICO to work with the enrollee and builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. All services must be provided in accordance with applicable state or local building codes.

Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as part of the cost of the service.

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

- The modification/adaptation must be the most cost-effective and reasonable alternative. The enrollee must use Medicaid state plan, Medicare, or other available payers first.

- MI Health Link HCBS waiver funds shall not be used for upgrades to the home or for additions to homes (adding square footage, etc.). MHL HCBS waiver funds shall only be used to modify existing spaces or structures.

- The modification/adaptation must be for a primary residence, but may include additional residences subject to prior authorization by the ICO. Examples of additional residences might be a family member's cottage or the enrollee's second home or cottage so the individual can go there and be with family.

- ICOs may use MHL HCBS waiver funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The direct service provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.

- This service does not include modifications to rental properties if the rental agreement states that it is the responsibility of the landlord to provide such modifications.

- Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the participant, and the ICO must specify any requirements for restoration of the property to its original condition if the occupant moves.

- Modifications must comply with local building codes.

- Repairs, modifications, or adaptations shall not be performed on a condemned structure or a home in the foreclosure process.

-The modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements.

- Excluded are those adaptations or improvements to the home that:
  - Are of general utility;
  - Are considered to be standard housing obligations of the enrollee or homeowner

(see examples in specific exclusions listed below of modifications that would be general utility and a standard obligation of the enrollee); and
  - Are not of direct medical or remedial benefit to the enrollee.

For example, a kitchen modification required for the enrollee to be able to prepare his or her own meals is a modification with a direct remedial benefit. Wheras, a general kitchen remodel is of general utility and a standard housing obligation of the enrollee.
  - Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless it is the most cost effective and reasonable alternative), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

- Environmental adaptations shall exclude costs for improvements exclusively required to meet local building codes and not directly related to an enrollee’s medical or physical condition.

- The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes.

- Environmental modifications required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in an enrollee’s home.

- The existing structure must have the capability to accept and support the proposed changes.

- The waiver does not cover general construction costs in a new home or additions to a home purchased after the enrollee is enrolled in the waiver. If an enrollee or the enrollee’s family purchases or builds a home while receiving

waiver services, it is the enrollee's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom if the enrollee has mobility limitations. However, waiver funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased.

- If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the waiver may be used to fund the difference between the standard fixture and the modification required to accommodate the enrollee's need.

- A ramp or lift will be covered for only one exterior door or other entrance.

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	Contracted Provider, Licensed Building Contractors
Individual	Contracted Provider, Licensed Building Contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Contracted Provider, Licensed Building Contractors

Provider Qualifications

License *(specify):*

MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2403(3)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to execution of contract

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:

Contracted Provider, Licensed Building Contractors

Provider Qualifications
License *(specify):*

MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2403(3)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to execution of contract.

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:

Expanded Community Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08030 personal care
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

To receive Expanded Community Living Supports (ECLS), enrollees MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete activities of daily living (ADLs) such as eating, bathing, dressing, toileting, other personal hygiene, etc. ECLS does not include hands on assistance for ADLs unless something happens to occur incidental to this service. Enrollees may also receive hands-on assistance for instrumental activities of daily living (IADLs) such as laundry, meal preparation, transportation, help with finances, help with medication, shopping, attending medical appointments, and other household tasks, as needed. ECLS also includes prompting, cueing, guiding, teaching, observing, reminding, and/or other support for the enrollee to complete the IADLs independently if he or she chooses. ECLS also includes social/community participation, relationship maintenance, and attendance at medical appointments.

ECLS may be furnished outside the enrollee's home. The enrollee oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to the IICSP.

Members of an enrollee's family may provide ECLS to the enrollee. However, ICOs shall not directly authorize funds to pay for services furnished to an enrollee by that person's spouse or legal guardian. Family members who provide this service must meet the same standards as providers who are unrelated to the enrollee.

Providers must be trained to perform each required task prior to service delivery. The supervisor must assure the provider can competently and confidently perform each assigned task.

ECLS provided in licensed settings includes only those services and supports that are in addition to and shall not replace usual customary care furnished to residents in the licensed setting.

ECLS does not include room and board costs.

When transportation is included as part of ECLS, the ICO shall not also authorize transportation as a separate waiver service.

ECLS does not include nursing and skilled therapy services.

ECLS may be provided in addition to Medicaid State Plan Personal Care Services if the enrollee requires hands-on assistance with some ADLs and/or IADLS, as covered under the State Plan service, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs or IADLs independently, but to ensure safety, health, and welfare of the enrollee.

Some activities under ECLS may also fall under activities in other waiver services. If other waiver services are used for these activities, this must be clearly identified in the IICSP and other documentation and billed under the appropriate procedure codes to avoid duplication of services.

MDHHS assures CMS that all residential and non-residential settings associated with the MI Health Link HCBS waiver are in compliance with the HCBS Final Rule prior to inclusion in the waiver and also with ongoing monitoring throughout the duration of the waiver. Prior to submission of the waiver applications to CMS, MDHHS did an evaluation of residential and non-residential settings that would be associated with the MI Health Link HCBS waiver to determine which settings would be included or excluded from the waiver. The results of this evaluation are indicated in the Appendix C, HCB Settings section of this waiver application. Any new settings that the ICO chooses to add to their provider network must be approved by MDHHS for HCBS Final Rule compliance. MDHHS's continual approval and monitoring of the settings throughout the duration of the waiver will ensure that ICOs are not using settings that have previously been added to the list of excluded settings and that still need to be excluded. Additionally, the continued monitoring will help MDHHS to identify any settings which were previously excluded but have since brought themselves into compliance. If the ICOs have selected settings that are noncompliant, the ICOs will be required to select different settings and resubmit to MDHHS for review and approval. MDHHS also has performance measures related to HCB setting compliance with the HCBS Final Rule as indicated in this waiver application.

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

Expanded Community Living Supports cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere. The distinction must be apparent by unique hours and units in the approved IICSP.

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
Individual	Individuals chosen by the enrollee

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expanded Community Living Supports

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-born pathogens, and be in good standing with the law as validated by a criminal history review.

2. A registered nurse licensed to practice nursing in the State shall furnish supervision of Expanded Community Living Support providers. At the State's discretion, other qualified individuals may supervise Expanded Community Living Supports providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing Expanded Community Living Support services.

3. The ICO and/or provider agency must train each worker to properly perform each task required for each enrollee the worker serves before delivering the service to that enrollee. The supervisor must assure that each worker can competently and confidently perform every task assigned for each enrollee served. MDHHS strongly recommends each worker delivering Expanded Community Living Support services complete a certified nursing assistance training course.

4. Expanded Community Living Support providers may perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each enrollee who requires such care. The supervising RN must assure each workers confidence and competence in the performance of each task required.

5. Individuals providing Expanded Community Living Support services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information, be trained in the enrollee's IICSP and reporting and identifying abuse and neglect. Additionally, skills, knowledge, and/or experience with food preparation, and safe food handling procedures, are highly desirable.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expanded Community Living Supports

Provider Category:

Individual

Provider Type:

Individuals chosen by the enrollee

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation incidental to this service, the provider must possess a valid Michigan driver's license.

2. Individuals providing Expanded Community Living Supports must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained in the enrollee's IICSP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.

3. Previous relevant experience and training to meet MDCH operating standards. Refer to the ICO contract for more details.

4. Must be deemed capable of performing the required tasks by ICO.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of services and 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 Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals

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

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

Service Definition *(Scope):*

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

The provision of one to two nutritionally sound meals per day to enrollees who are unable to care for their nutritional needs.

This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law.

Meal options must meet enrollee preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences.

Each provider shall document meals served.

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

Federal regulations prohibit from providing three meals per day to enrollees. Meal service should be offered in relation to variable availability of allies or formal caregivers and changes in the enrollee's condition.

Meals authorized under this service shall not constitute a full nutrition regimen.

Meals shall not include dietary supplements.

Limitations on who can get a meal:
- The participant must be unable to obtain food or prepare complete meals.
- The participant does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
- The participant does not have a paid caregiver that is able and willing to prepare meals for the participant.
- The provider can appropriately meet the participant's special dietary needs and the meals available would not jeopardize the health of the individual.
- The participant must be able to feed himself/herself.
- The participant must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

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 Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

Health Code Standards (PA 368 of 1978)

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Each Home Delivered Meals provider shall have the capacity to provide two meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider shall have meals available at least five days per week.

2. Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.

3. Each provider shall carry product liability insurance sufficient to cover its operation.

4. The provider shall deliver food at safe temperatures as defined in Home Delivered Meals service standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to the initial delivery of services and 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:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service offered to enable enrollees to gain access to waiver and other community services, activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP).

Whenever possible, the ICOs shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge.

Direct service providers shall be a centrally organized transportation company or agency.

The following methods can be used for transportation: 1) demand/response (door-to-door, curb-to-curb service on demand), 2) public transit, 3) volunteer, 4) ambu-cab (on demand wheelchair accessible van).

Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance.

As applicable, other funding sources shall be utilized prior to using waiver funds, including Department of Human Services authorizations for medical transportation.

Waiver funds may not be used to purchase or lease vehicles for providing transportation services to waiver enrollees.

Waiver funds shall not be used to reimburse caregivers (paid or informal) to run errands for enrollees when the enrollee does not accompany the driver of the vehicle.

Specify applicable (if any) limits on the amount, frequency, or duration of 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
Individual	Individual
Agency	Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Valid Michigan Driver's License

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All drivers must be licensed and all vehicles registered by the Michigan Secretary of State for transportation supported by MI Health Link waiver funds. The participant or vehicle owner must cover all vehicles used with automobile insurance.

2. All paid drivers for transportation providers supported entirely or in part by waiver funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles.

3. Each provider shall operate in compliance with Public Act 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to the initial delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Contracted Provider

Provider Qualifications

License *(specify):*

Valid Michigan Driver's License

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All drivers must be licensed and all vehicles registered by the Michigan Secretary of State for transportation supported by MI Health Link waiver funds. The provider must cover all vehicles used with liability insurance.

2. All paid drivers for transportation providers supported entirely or in part by waiver funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

3. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

4. Each provider shall comply with Public Act 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to the initial delivery of services and 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:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

This electronic device enables enrollees to secure help in an emergency. The enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the enrollee's phone and programmed to signal a response center once a "help" button is activated.

The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The enrollee must reside in an area where the cellular or mobile coverage is reliable. When the enrollee uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.

The provider will assure at least monthly testing of each PERS unit to assure continued functioning.

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

PERS does not cover monthly telephone charges associated with phone service.

PERS is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. ICOs may authorize PERS units for persons who do not live alone if both the waiver enrollee and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. An example of this is two individuals who live together and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

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	Personal Emergency Response System Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Personal Emergency Response System Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

2. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.

3. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.

4. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of services and 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:

Preventive Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an enrollee who generally requires nursing services for the management of a chronic illness or physical disorder in the enrollee's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for enrollees who require more periodic or intermittent nursing than otherwise available for the purpose of preventative interventions to reduce the occurrence of adverse outcomes for the enrollee such as hospitalizations and nursing facility admissions. An enrollee using this service must demonstrate a need for observation and evaluation. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more nursing services. Observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, and physical status. Additional nursing services include medication set-up, administration and monitoring, dressing changes, range of motion assistance and/or monitoring, refresher training to the beneficiary and/or caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home.

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

- This service is limited to no more than two hours per visit
- Enrollees receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services
- All providers must be licensed in the State of Michigan as a Registered Nurse or Licensed Practical Nurse
- This service must not duplicate Home Health Services

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
Individual	Licensed Practical Nurse or Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Preventive Nursing Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201-17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing nursing services to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Each direct service provider must have written policies and procedures compatible with the operating standards document(s) which will be provided to ICOs.

3. Services paid for with waiver funds shall not duplicate nor replace other services available through the Michigan Medicaid state plan or Medicare.

4. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to the initial delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Preventive Nursing Services

Provider Category:
Individual
Provider Type:

Licensed Practical Nurse or Registered Nurse

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 ... 333.17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing Preventive Nursing Services to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Services paid for with waiver funds shall not duplicate nor replace other services available through the Michigan Medicaid state plan or Medicare.

3. This service may include medication administration as defined under the referenced statutes.

4. It is the responsibility of the LPN to secure the services of an RN to supervise his or her work.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of service and 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:

Private Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Private Duty Nursing (PDN) services are skilled nursing interventions provided to an enrollee age 21 and older on an individual and continuous basis, up to a maximum of 16 hours per day, to meet the enrollee's health needs directly related to the enrollee's physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the enrollee's IICSP.

Medical Criteria I – The enrollee is dependent daily on technology-based medical equipment to sustain life.
"Dependent daily on technology-based medical equipment" means:
1. Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
2. Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
3. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
4. Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
5. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.
Definitions:
1. "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
2. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
3. "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
4. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
5. "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.
6. "Substantiated" means documented in the clinical or medical record, including the nursing notes.

Medical Criteria III – The enrollee requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.
Definitions:
1. "Continuous" means at least once every 3 hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.
2. "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
a. Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
b. Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the enrollee four or more hours per day;
c. Deep oral (past the tonsils) or tracheostomy suctioning;
d. Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
e. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required,

associated with complex medical problems or medical fragility;
f. Total parenteral nutrition delivered via a central line and care of the central line;
g. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;
h. Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

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

To be eligible for PDN services, the ICO must find the enrollee meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III (see criteria above under Service Definition). Regardless of whether the enrollee meets Medical Criteria I or II, the enrollee must also meet Medical Criteria III.

Enrollees receiving Preventive Nursing Services are not eligible to receive Private Duty Nursing Services.

PDN may include medication administration according to MCL 333.7103(1).

This service must be ordered by a physician, physician's assistant, or nurse practitioner.

This service is not intended to be used on a continual basis for 24 hours, 7 days per week. PDN is intended to supplement informal support services available to the enrollee.

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	Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)
Agency	private duty nursing agency, home care agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Individual
Provider Type:

Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 ... 333.17242

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN.

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing Private Duty Nursing to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2 Services paid for with waiver funds shall not duplicate nor replace services available through the Michigan Medicaid state plan or Medicare.

3. This service may include medication administration as defined under the referenced statutes.

4. It is the responsibility of the LPN to secure the services of an RN to supervise his or her work.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to the initial delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

private duty nursing agency, home care agency

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 ... 333.17242

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN.

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing private duty nursing to enrollees must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Services paid for with waiver funds shall not duplicate nor replace services available through the Michigan Medicaid state plan or Medicare.

3. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

ICO

Frequency of Verification:

Prior to initial delivery of services and annually thereafter.

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

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

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

ICO Care Coordinators will facilitate the care coordination process for the MI Health Link 1915(b)/(c) waiver program.

Responsibilities of the ICO Care Coordinator are as follows:
- Update the ICBR as needed pertinent to the team member's role on the ICT
- Review assessment, test results and other pertinent information in the ICBR
- Address transitions of care when a change between care settings occur
- Ensure continuity of care and coordinate care transitions
- Monitor for issues related to quality of care and quality of life
- Complete the Level I Assessment
- Prepare the IICSP
- Lead the ICT
- If the enrollee is receiving services that require meeting the Nursing Facility Level of Care standards, assure that the enrollee continues to meet the criteria or transitions to services that do not require NFLOC standards.
- Arrange services as identified in the IICSP
- Update the ICBR with current enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery
- Monitor service implementation, service outcomes, and the enrollee's satisfaction
- Collaborate with the ICO Care Coordinator to assist the enrollee during transitions between care settings, including full consideration of all options
- Advocate for the enrollee and support self-advocacy by the enrollee

The Care Bridge:
The Care Bridge is the care coordination framework for the MI Health Link §1915(b)/(c) waiver. Through the Care Bridge, the members of the enrollee's care and supports team facilitate access to formal and informal services and supports identified in the enrollee's Individual Integrated Care and Supports Plan (IISCP) developed through a person-centered planning process. The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the care and supports team.
Care coordination services will provide for:
• A person-centered, outcome-based approach, consistent with the CMS model of care (MOC) and Medicare and Medicaid requirements and guidance.
• The opportunity for the enrollee to choose arrangements that support self-determination.
• Appropriate access and sharing of information. Enrollees and treating providers will have access to all the information in the Integrated Care Bridge Record (ICBR). It is the Enrollee's right to determine the appropriate involvement of other members of the ICT in accordance with applicable privacy standards.
• Medication review and reconciliation.

Individual Integrated Care and Supports Plan (IICSP)
The IICSP will be completed for all enrollees within 90 calendar days of enrollment. Existing person-centered service plans or plans of care can be incorporated into the IICSP.

Assessment Process:
The assessment process includes three steps: 1) Initial Screening using specified screening questions at the time of enrollment; 2) completion of the Level I Assessment using an approved tool; and 3) the Level II Assessment for enrollees identified as having needs related to long term supports and services (LTSS), behavioral health(BH), substance use disorders(SUD), or intellectual/developmental disability(I/DD) services or complex medical needs. The assessment process must be completed for all enrollees. Existing assessments and person-centered service plans or plans of care can be incorporated into the assessment and IICSP.

Integrated Care Team(ICT):
An ICT will be offered to the enrollee. The ICT will honor the enrollee's choice about his or her level of participation. This choice will be revisited periodically by the ICO Care Coordinator as it may change. The ICO Care Coordinator will be the lead of the ICT. Membership will also include the enrollee and the enrollee's chosen allies, primary care physician/designee, and LTSS Supports Coordinator &/or PIHP Supports Coordinator(as applicable).

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):

ICOs are required to conduct criminal history/background investigations on providers. Fingerprint background investigations are required for professional state licensure and also for individuals and providers covered under Michigan Public Acts 27, 28 and 29 of 2006. Criminal history/background investigations will also be required for compliance with any future policy or legislation.

Each ICO and direct provider of MI Health Link HCBS waiver services must conduct a criminal history review for each paid or volunteer staff person who will be entering homes of enrollees. The ICO and direct provider shall conduct the reference and criminal history reviews before authorizing the individual to provide services in an enrollee's home.

Both the ICO and MDHHS conduct quailty assurance reviews of providers annually to verify that mandatory criminal history reviews have been conducted in compliance with operating standards.

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

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

Appendix C: Participant Services

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

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

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Long Term Care Facility	
Home for the Aged	
Adult Foster Care Home	

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

The State of Michigan licenses five types of Adult Foster Care (AFC) homes that are used. Capacity limit for Family Homes are 1 - 6; Small Group Homes are 1-12; Medium Group Homes are 7-12; Large Group Homes are 13-20; and Congregate Homes are larger than 21 residents. Michigan is phasing out the licensing of Congregate Homes, but existing homes continue to operate.

Homes For The Aged (HFA)are supervised personal care facilities (other than a hotel, adult foster care facility, hospital, nursing facility, or county medical care facility) that provide room, board, and supervised personal care to unrelated, nontransient individuals 60 years of age or older. Each HFA is licensed for a specific number and cannot exceed that capacity.

Home-like characteristics are maintained in these settings supported by the licensing criteria that have been established for this purpose. These criteria for AFC homes are found in Section 9 of Act No. 380 of the Public Acts of 1965, as amended, and Section 10 and 13 of Act No. 218 of the Public Acts of 1979, as amended. Family Home rules are referenced under MCL rules 400.1401 - 400.1442 and 400.2201 - 400.2261; Small and Medium Group Homes are under MCL 400.1401 - 400.1442 and 400.14101 - 14601; Large Group Homes are under MCL 400.15101 - 400.15411; and Congregate Homes are under MCL 400.2101 - 400.2122, 400.2401 - 400.2475, and 400.2501 - 400.2567. HFA's are established under Act No. 368 of 1978 as amended, sections MCL 333.21301 - 333.21335.

These rules address licensee responsibilities to residents' rights, physical environmental specifications and maintenance.

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

All AFCs and HFAs have full kitchens, and snacks and beverages must be available to all residents. Michigan requires that residents be allowed privacy for visitations. If visiting hours are established, AFCs and HFAs indicate visiting times during reasonable hours and applicable to all residents and shall take into consideration the special cirumstances of each visitor and tweak these visiting hours as needed to try to accommodate schedules of visitors to the extent that it will not cause occupancy issues. Limitations on visiting time must be written in the residency agreement and signed by the enrollee or his or her legal representative. Residential settings and non-residential settings must comply with the HCBS Final Rule.

MDHHS assures CMS that all residential and non-residential settings associated with the MI Health Link HCBS waiver are in compliance with the HCBS Final Rule prior to inclusion in the waiver and also with ongoing monitoring throughout the duration of the waiver. Prior to submission of the waiver applications to CMS, MDHHS did an evaluation of residential and non-residential settings that would be associated with the MI Health Link HCBS waiver to determine which settings would be included or excluded from the waiver. The results of this evaluation are indicated in the Appendix C, HCB Settings section of this waiver application. Any new settings that the ICO chooses to add to their provider network must be approved by MDHHS for HCBS Final Rule compliance. MDHHS’s continual approval and monitoring of the settings throughout the duration of the waiver will ensure that ICOs are not using settings that have previously been added to the list of excluded settings and that still need to be excluded. Additionally, the continued monitoring will help MDHHS to identify any settings which were previously excluded but have since

brought themselves into compliance. If the ICOs have selected settings that are noncompliant, the ICOs will be required to select different settings and resubmit to MDHHS for review and approval.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Long Term Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	☐
Fiscal Intermediary	☐
Non-Medical Transportation	☐
Chore Services	☐
Community Transition Services (terminated effective 04/24/2019)	☐
Personal Emergency Response System	☐
Adaptive Medical Equipment and Supplies	☐
Home Delivered Meals	☐
Adult Day Program	☐
Expanded Community Living Supports	☐
Preventive Nursing Services	☐
Assistive Technology	☐
Respite	☒
Environmental Modifications	☐

Facility Capacity Limit:

any number

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒

Standard	Topic Addressed
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Home for the Aged

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	☐
Fiscal Intermediary	☒
Non-Medical Transportation	☒
Chore Services	☐
Community Transition Services (terminated effective 04/24/2019)	☐
Personal Emergency Response System	☐
Adaptive Medical Equipment and Supplies	☒
Home Delivered Meals	☐
Adult Day Program	☐
Expanded Community Living Supports	☒
Preventive Nursing Services	☒
Assistive Technology	☒
Respite	☒
Environmental Modifications	☐

Facility Capacity Limit:

21+

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

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Foster Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Private Duty Nursing	☒
Fiscal Intermediary	☒
Non-Medical Transportation	☒
Chore Services	☐
Community Transition Services (terminated effective 04/24/2019)	☐
Personal Emergency Response System	☐
Adaptive Medical Equipment and Supplies	☒

Waiver Service	Provided in Facility
Home Delivered Meals	☐
Adult Day Program	☐
Expanded Community Living Supports	☒
Preventive Nursing Services	☒
Assistive Technology	☒
Respite	☒
Environmental Modifications	☐

Facility Capacity Limit:

20

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

Scope of State Facility Standards

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or

adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

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

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

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

- ( ) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

Relatives who are not legally or financially responsible for the enrollee may be paid for services rendered if they meet provider qualifications indicated in this waiver application.

- ( ) **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:

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

The ICOs are responsible to determine that providers are qualified to provide requested waiver service(s) prior to the provision of services and supports and annually thereafter. There are no limits on the number of qualified service providers with which an ICO or subcontractor agency may contract, if all the standards, certifications and licensure requirements have been met.

After service provider qualifications are reviewed and verified by the ICO, the ICO enrolls the provider as a Medicaid provider using a contractual agreement and the Medicaid Provider Enrollment agreement. The Medicaid agency delegates the ICO to maintain signed and executed contractual agreements on file.

MDHHS reviews the ICOs provider monitoring policies, provider network lists, and provider monitoring reviews to ensure that sufficient and qualified providers are available to serve participants.

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 licensed/certified waiver service providers that meet provider qualifications prior to the provision of waiver services. Numerator:Number of licensed/certified waiver service providers that meet initial licensure/certification standards prior to the provision of waiver services. Denominator: Total number of new licensed/certified providers.

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

Record reviews on/off site, interview and monitoring

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: ICOs	☐ **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 licensed/certified providers that continue to meet applicable qualifications following initial contracting. Numerator: Number of licensed/certified providers that continue to meet applicable qualifications following initial contracting. Denominator: Total number of existing licensed/certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ICOs: Record Review on/off site, interviews and monitoring. MDHHS: ICO reports

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

		ICOs review a minimum of 10% of waiver service providers annually. MDHHS reviews 100% of the data collected and submitted by ICOs.
	☐ **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 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 or non-certified waiver providers that continue to meet applicable qualifications following initial contracting. Numerator: Number of non-licensed or non-certified waiver providers that continue to meet applicable qualifications following initial contracting. Denominator: Total number of existing non-licensed non-certified waiver service providers reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
ICOs: Record Review on/off site, interviews and monitoring. MDHHS: ICO reports

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

		ICOs review a minimum of 10% of waiver service providers annually. MDHHS reviews 100% of the ICO data that is collected and submitted.
	☐ **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 non-licensed or non-certified waiver providers that meet provider qualifications prior to the provision of waiver services. Numerator: Number of non-licensed or non-certified waiver providers that meet provider qualifications prior to the provision of waiver services. Denominator: Total number of new non-licensed or non-certified waiver service providers.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Record reviews on/off site, interview and monitoring

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

Data Aggregation and Analysis:

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

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

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 Care Coordinators and LTSS Supports Coordinators who have completed all the required Learning Management System (LMS) training modules within required timeframes. Numerator: Number of Care Coordinators & LTSS Supports Coordinators who have completed the required LMS training modules within required timeframes. Denominator: All Care Coordinators & LTSS Supports Coordinators.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to MDHHS, online database, other reports

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: ICO	☒ **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.

ICOs are responsible for conducting monitoring of their waiver service providers to ensure compliance with provider qualifications and standards. ICOs are responsible to ensure provider compliance prior to delivery of service and annually thereafter. ICOs complete monitoring reviews on all new providers prior to delivery of service. ICOs ensure on an annual basis that all providers can continue to meet the applicable qualifications and standards. Additionally, ICOs complete monitoring reviews for a minimum of 10% of their waiver service providers annually according to MI Health Link Provider Monitoring Plan (found in Minimum Operating Standards). The ICO assigns one or two staff that has primary responsibility
for conducting provider reviews.

The ICO conducts initial monitoring prior to the delivery of services when contracting with a new waiver service provider. The ICO must complete the following forms related to this activity:
• MI Health Link Provider Monitoring Cover Page
• Provider Qualifications Form (specific to the type of provider)
- If the ICO can make a determination using the Provider Qualifications Form that the provider meets all applicable standards through an off-site record review that is acceptable. However, there may be instances when the ICO will need to conduct an on-site review.
The ICO notifies the provider of their findings within 30 days of conducting the monitoring utilizing the MDHHS provided letter template. This notification must indicate whether the provider has been determined by the ICO to be compliant or non-compliant with the applicable qualifications. If the provider has been determined to be non-compliant, the provider shall not provide waiver services until the ICO has confirmed compliance.
Annually, the ICO ensures through their contract renewal process, contract review with the provider, or other methodology defined by their policy that the provider continues to be compliant with all applicable provider qualifications.
ICOs complete monitoring reviews for a minimum of 10% of their waiver service providers annually. The ICO develops a yearly schedule of provider monitoring reviews to conduct monthly throughout the calendar year, January 1 to December 31. The schedule must include a minimum of 10% of their waiver service providers. The schedule for the upcoming year is submitted to MDHHS by December 1st of each year via the FTP utilizing the file name “provider monitoring schedule.” When developing the annual schedule, the Integrated Care Organization should consider prior year(s) schedule(s) and ensure that the types of providers selected for monitoring reviews vary and the same providers are not repeated year after year.
The ICO must complete the following forms related to this activity:
• MI Health Link Provider Monitoring Cover Page
• Provider Qualifications Form (specific to the type of provider)
- If the Integrated Care Organization can make a determination using the Provider Qualifications Form that the provider meets all applicable standards through an off-site record review that is acceptable. However, there may be instances when the Integrated Care Organization will need to conduct an on-site review.
• Billing Audit
The Integrated Care Organization develops a sample of enrollee records to review for the Billing Audit. The sample should be 5 records or 10% of the records for the ICO’s enrollees served by the provider (whichever is greater.) The Integrated Care Organization will establish a timeframe (a three month period is adequate though may need to be expanded to capture service dates if there are a limited number of ICO enrollees served by the provider. The Billing Audit can be on-site at the provider’s location, or through off-site record review. The billing audit is used to verify billing dates and units of service submitted by the provider and paid by the ICO with dates and units found in the provider’s enrollee records.
• Two (2) MI Health Link Enrollee Contact Forms per provider monitored
The enrollee contact form allows the Integrated Care Organization to obtain comments regarding service provision from the perspective of the enrollee. Additionally, the contact allows for a comparison between the Individual Integrated Care and Supports Plan (IICSP) and the services delivered per the enrollee. The Enrollee Contact Form can be completed in-person or telephonically.

Following a monitoring activity, the Integrated Care Organization notifies the provider and MDHHS of their findings within 30 days of conducting the monitoring utilizing the MDHHS provided letter template. This notification must indicate whether the provider has been determined by the Integrated Care Organization to be compliant or non-compliant with the applicable qualifications.

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 any non-compliance is determined during any type of monitoring review, the ICO will notify the provider and MDHHS within 30 days of the review and establish the need for the provider to complete a corrective action plan along with a deadline for compliance to be achieved and a timeline for a re-evaluation. The ICO must submit all additional communications/findings related to the monitoring up to and including the final compliance letter. The Integrated Care Organization reviewer ensures the enrollee's care coordinator is aware of pertinent information such as concerns regarding service delivery that the
reviewer gathers during the home visit interviews. Care coordinators follow-up with enrollee concerns identified during the home visits. When findings warrant immediate action to protect the enrollee's health or welfare the ICO will suspend new referrals to the provider agency or transfer enrollees to another provider. When billing audit findings reveal non-compliance, the ICO must adjust provider billings using individual adjustments to date of service or gross adjustment. Overpayments must be deducted from the next warrant issued the provider and encounter data submitted to CHAMPS must be corrected to accurately reflect adjustments made to provider billing. ICOs must suspend or terminate the providers who demonstrate a failure to correct deficiencies identified through the review process. The ICO can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required. If an ICO terminates a provider they must notify MDHHS and MDHHS will notify other ICOs as warranted to mitigate potential harm to other MI Health Link enrollees. MDHHS will monitor all provider monitoring reviews conducted and submitted by the ICOs to ensure any provider determined to be non-compliant with any applicable qualification corrects the issue and achieves compliance or is terminated as a provider. If an ICO is found to be non-compliant with the monitoring of their waiver service providers MDHHS will utilize the CAP process outlined in Appendix A of this application.

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. MI Health Link participants who reside in their own home or in the home of their relative (non-provider controlled) and receive home and community-based services comply with the federal HCB Settings requirements. These settings allow the participants to be in control of their life and be fully integrated in the community.

2) MDHHS conducted an evaluation of settings using materials including State laws, licensing rules and regulations, surveys of individuals in the field and existing licensed homes and other settings. Residential and non-residential settings will be monitored by both ICOs and MDHHS. During the provider network validation process required by CMS for the MI Health Link program, MDHHS will assure each non-residential setting under contract with ICOs are in compliance with the HCBS Final Rule. Similarly, ICOs will be required to evaluate a MI Health Link HCBS waiver applicant's residential setting prior to sending an initial application to MDHHS for review. The residential setting's compliance or non-compliance with the HCBS Final Rule must be documented and included in the case record at the ICO and also included in the application packet sent to MDHHS for initial MI Health Link HCBS waiver approval. MDHHS will verify the settings compliance prior to approving an individual for MI Health Link HCBS waiver enrollment. MDHHS, through the MI Health Link HCBS Quality Improvement Strategy and associated performance measures, will annually (or more often as needed) monitor residential and non-residential setting compliance with the HCBS Final Rule and will report results to CMS during required reporting periods.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Integrated Care and Supports Plan (IICSP)

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:

A Michigan licensed registered nurse, nurse practitioner, clinical nurse specialist, physician's assistant, Bachelor's prepared limited or full licensed social worker, Limited License Master's prepared social worker, Licensed Master's prepared social worker. The ICO Care Coordinator or the ICO's contracted community partners (as described in the Three-Way Contract) will conduct at a minimum the Level I Assessment, assure the person-centered planning process is complete, prepare the Individual Integrated Care and Supports Plan (IICSP), coordinate care transitions and lead the Integrated Care Team (ICT). Care Coordinators must coordinate these activities with the PIHP Supports Coordinator/Case Manager or LTSS Supports Coordinator and ICT members as appropriate.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

The ICO Care Coordinator, the enrollee, his or her family, caregiver or authorized representative, providers, other members of the Integrated Care Team, and any other individuals of the enrollee's choosing work together to develop a comprehensive, person-centered, written Individual Integrated Care and Supports Plan (IICSP). The ICO Care Coordinator has the ultimate responsibility for ensuring the IICSP is completed in accordance with the enrollee's choices, goals, and desires. The ICO Care Coordinator develops the IICSP in collaboration with other individuals of the enrollee's choosing. Though service providers may be involved in the person-centered planning process, the ICO Care Coordinator does not directly provide waiver services to the enrollee.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

a) ICOs provide the MI Health Link Member Handbook or information on how the beneficiary can access the handbook to all enrollees during the enrollment process. The Handbook explains the MI Health Link supports and services, rights and appeals information, information about obtaining medications, and other information relevant to the service area. Enrollees will also receive a Summary of Benefits, a List of Covered Drugs, a Provider Directory, and an enrollee ID card which includes numbers to contact for certain questions or emergencies.

ICOs solicit enrollee preferences for date, time, and place of the assessment meeting before finalizing schedules. The enrollee, his or her chosen allies, and family or legal representatives are provided with written information about the right to participate in a person-centered planning process and the self-determination option upon enrollment in MI Health Link, during assessment, reassessment, or upon request. The ICO Care Coordinator, and LTSS Supports Coordinator as applicable, provides additional information and support and directly addresses issues and concerns the participant may have either over the phone or in a face-to-face meeting. Continued assistance from the ICO Care Coordinator or LTSS Supports Coordinator is available throughout the person-centered planning process. MDHHS has developed person-centered planning principles for ICOs, enrollees, and other individuals to use as a guide for the person-centered planning process.

b) The enrollee has authority to determine who will be involved in the person-centered planning process and may choose allies, such as family members, friends, community advocates, service providers and independent advocates to participate. If preferred by the enrollee, a pre-planning conference may occur before the person-centered planning meeting. In this pre-planning conference, the participant, the ICO Care Coordinator, and the LTSS Supports Coordinator, as applicable, discuss who the enrollee wants to involve in the planning process, goals and desires that will be addressed, topics that will be discussed at the meeting and topics that will not be addressed. The time and location for the planning meeting is also determined at the pre-planning session.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Who develops the plan, who participates in the process, and the timing of the plan:
After completing the Nursing Facility Level of Care Determination tool, the Level I Assessment and the Level II Assessment, the ICO Care Coordinator and LTSS Supports Coordinators, as applicable, work with the enrollee and his or her representatives to develop the Individual Integrated Care and Supports Plan (IICSP).

If the enrollee is experiencing a crisis situation that requires immediate services at the time of enrollment and is not ready to fully participate in person-centered planning, an interim IICSP may be developed by the ICO Care Coordinator and LTSS Supports Coordinator, as applicable, and approved by the enrollee. Interim service plans are authorized for no more than 30 days without a follow-up visit to determine the enrollee's status. The first person-centered planning meeting is conducted when the participant is not in crisis and at a time of the participant’s choice.

A pre-planning session may occur before the first person-centered planning meeting. During pre-planning, the enrollee chooses desires, goals and any topics to be discussed, who to invite, who will facilitate and record the meeting, as well as a time and location that meets the needs of all individuals involved in the process. The enrollee and selected allies design the agenda for the person-centered planning meeting. The IICSP is based on the needs and desires as communicated by the enrolee and is updated upon request of the enrollee. Regular updates also occur when the need for services or enrollee circumstances change, but at least once every twelve months.

(b) The types of assessments that are conducted to support the IICSP development process, including securing information about enrollee needs, preferences and goals, and health status:

The Level I Assessment is the ICO's Health Risk Assessment that must be conducted by the ICO Care Coordinator and completed within 60 days of enrollment in the MI Health Link program. The Level I Assessment covers the following domains: physical health; behavioral health; psychosocial; LTSS needs; individual preferences and strength and goals; natural supports or other caregiver capacity; current services; care transition needs; medical health risk status and history; behavioral health and substance use risk status, needs, and history; nutritional stregths and needs; cognitive strengths and needs; quality of life; discussion and education related to abuse, neglect, and exploitation; and advance directives. The Level I Assessment will also help the ICO Care Coordinator identify enrollees who may require institutional level of care. The Level I Assessment tools will be approved by MDHHS prior to use by the ICO.

The specific Level II Assessment for LTSS will be the interRAI Home Care (iHC) assessment system, consisting of the iHC and clinical assessment protocols (CAPs). The ICO Care Coordinator or the LTSS Supports Coordinator perform, within 15 days of the completion of the Level I Assessment, a comprehensive evaluation including assessment of the enrollee’s unique preferences, physical, social and emotional functioning, medication, physical environment, natural supports, and financial status. The ICO Care Coordinator or the LTSS Supports Coordinator must fully engage the enrollee in the interview to the extent of the enrollee’s abilities and tolerance.

Specific iHC items identify enrollees who could benefit from further evaluation and those who are at risk for functional decline. These items, called “triggers,” link the iHC to a series of problem oriented CAPs. The CAPs are procedures that guide coordinators through further assessment and individualized care planning with enrollees.

(c) How the participant is informed of the services that are available under the waiver:

The ICO Care Coordinator or LTSS Supports Coordinator informs the enrollee of available services. This occurs through direct communication with the ICO Care Coordinator or LTSS Supports Coordinator as well as through written information provided to the enrollee regarding waiver services and other available community services and supports. The enrollee is offered information on all possible service providers. The enrollee specifies how he/she wishes to receive services and this is included in the IICSP.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

MDHHS developed a person-centered planning practice guide/training for ICOs. The documents/training are provided to ICOs to assist the ICO Care Coordinator and LTSS Supports Coordinator in ensuring that the IICSP clearly identifies the enrollee's needs, goals and preferences with the services specified to meet them.

The ICO Care Coordinator and LTSS Supports Coordinator and enrollee base the IICSP upon enrollee preferences and

needs identified through the person-centered planning process. A written IICSP is developed with each enrollee and includes the enrollee's identified or expressed needs, goals, expected outcomes, and planned interventions, regardless of funding source. This document includes all services provided to or needed by the enrollee and is developed before MI Health Link services are provided. The ICO Care Coordinator and/or LTSS Supports Coordinators arrange services based upon enrollee choice and approval. The enrollee and the ICO Care Coordinator and/or LTSS Supports Coordinator explore other funding options and intervention opportunities when personal goals include things beyond the scope of MI Health Link services.

Specific information that needs to be addressed in the IICSP:
1) Enrollee's preferences for care, services, supports, residential settings, and non-residential settings
- Must include supports and services options that were discussed with the enrollee, and his or her (or legal representative's) choice of those services
- When the enrollee selects controlled residential settings such as licensed Adult Foster Care or Homes for the Aged, or others, the following must be included in the IICSP
  - The chosen setting
  - The individual's resources
  - Whether or not the individual chooses to have a roommate as well as any specific preferences for roommates, bathroom schedules, or other things
  - Preference for engaging in community activities outside the home, and whether or not the individual needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen
  - Personal safety risks, and any interventions, that may affect the individual's ability to engage in community activities outside the home without supervision
  - Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an enrollee's assessed needs; indicate established timeframes for periodic review of these modifications

2) Enrollee's health and safety risks
3) Enrollee's prioritized list of concerns, goals and objectives, strengths
4) Summary of the enrollee's health status
5) The plan for addressing concerns or goals, actions for achieving the goals, and specific providers, supports and services including amount, scope and duration
  - Must include the enrollee's (or legal representative's) rights and choices of specific providers (and alternative providers, if necessary)
  - Must include a contingency (backup) plan for providers in the event of unscheduled absence of a caregiver, severe weather, or other emergencies
6) Person(s) responsible for specific monitoring, reassessment, and evaluation of health and well-being outcomes
7) Enrollee's informed consent
8) Due date for interventions and reassessment

(e) How waiver and other services are coordinated and by whom:

The IICSP clearly identifies the types of services needed from both paid and non-paid providers of services and supports. The amount (units), frequency, and duration of each waiver service to be provided are included in the IICSP. The enrollee chooses the services that best meet his or her needs and whether to use the option to self-direct applicable services or rely on a supports coordinator to ensure the services are implemented and provided according to the IICSP. When an enrollee chooses to participate in arrangements that support self-determination, information, support and training are provided by the ICO Care Coordinator and/or LTSS Supports Coordinator and others identified in the IICSP. When an enrollee chooses not to participate in self-determination, the coordinator ensures that services and supports are implemented as planned. The ICO Care Coordinator and LTSS Supports Coordinators, as applicable, oversee the coordination of State Plan and waiver services included in the IICSP. This oversight ensures that waiver services in the IICSP are not duplicative of similar State Plan services available to or received by the enrollee.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The assignment of responsibilities to implement the plan are determined through person-centered planning and may be

delegated to the enrollee, the ICO Care Coordinator, an LTSS Supports Coordinator, or others designated by the enrollee. The ICO Care Coordinator, and the LTSS Supports Coordinator (if applicable) and the enrollee, to the extent the enrollee chooses, are responsible for monitoring the plan. This occurs through periodic case reviews, monthly contacts, participant request, reassessments, and routine formal service provider monitoring of expenditures made on behalf of the enrollee.

(g)How and when the plan is updated:

ICOs are required to contact enrollees monthly. Reassessments are conducted in person annually or upon a significant change in the enrollee's condition. The ICO Care Coordinator or LTSS Supports Coordinator conducts an in person reassessment of the enrollee for the purpose of identifying changes that may have occurred since the initial assessment or previous reassessment and to measure progress toward meeting specific goals outlined in the IICSP. The IICSP is also reviewed and updated during this process, based upon reassessment findings and enrollee preferences. The IICSP is also updated after changes in status and upon participant request.

In accordance with the Final Rule, the IICSP must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. The IICSP must be distributed to the individual and other people involved in the plan.

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.

The ICO Care Coordinator or LTSS Supports Coordinator identifies and discusses potential risks with the enrollee during the assessment and reassessments. The process specifies risks and methods of monitoring their potential impact in relation to the enrollee. The ICO Care Coordinator or LTSS Supports Coordinators, or other qualified individuals, fully discuss strategies to mitigate risks with the enrollee and allies, family, and relevant others during the person-centered planning process. Enrollee approved risk strategies are documented and written into the IICSP. Enrollees may be required to acknowledge situations in which their choices pose risks for their health and welfare. The ICO is not obligated to authorize services believed to be harmful to the enrollee. Negotiations of such issues are initiated in the person-centered planning process. The ICO Care Coordinator or LTSS Supports Coordinator assesses and informs the enrollee of identified potential risk(s) to assist enrollees in making informed choices with regard to these risks. Service providers are informed of an enrollee's risk status when services are ordered. ICOs and service providers are required to have contingency plans in place in the event of emergencies that pose a serious threat to the enrollee's health and welfare (i.e., inclement weather, natural disasters, and unavailable caregiver).

The enrollee's IICSP describes back-up plans that are to be implemented when selected service providers are unable to render services as scheduled. Additionally, emergency plans that clearly describe a course of action when an emergency situation occurs are developed for each enrollee. Plans for emergencies are discussed and incorporated into the enrollee's IICSP as a result of the person-centered planning process.

Qualified reviewers examine a random sample of back-up and emergency plans during the quality assurance review to assure plans are properly documented, meet enrollee needs, and include risk management procedures.

In addition, the MI Health Link HCBS Quality Improvement Strategy requires ICOs to monitor and track when backup plans are activated and whether or not they are successful in an effort to make improvements in the way back-up plans are developed with enrollees.

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.

The ICO Care Coordinator or LTSS Supports Coordinator provides enrollees with information and training on selecting qualified service providers. Information may also be provided by the enrollee's support network. Service providers must meet the minimum standards established by MDHHS for each service. Enrollees choose among qualified providers or employ providers who meet the minimum standards. ICO Care Coordinators, LTSS Supports Coordinators, or others, may assist enrollees as needed to identify and select qualified providers at any time. A brochure, developed by MDHHS and ICOs, on how to find and hire workers is distributed to enrollees via ICOs.

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):

ICO Care Coordinators are responsible for securing and verifying level of care (LOC) eligibility, conducting assessments and reassessments, initiating service planning and the person-centered planning process with participants, and specifying approval of IICSPs. Prior to intial entrance on the waiver, the ICO must send all relevant assessments and medical records to MDHHS for review and approval for a waiver slot.

MDHHS uses a quality assurance review process to meet CMS requirements for the review of service plan authorizations and case record reviews. The quality assurance review process reviews a sample of the waiver population as identified by www.raosoft.com/samplesize.html using a 95% confidence level and +/- 5% margin of error to determine total number of records to review for each ICO each waiver year. Records reviewed are a random sample of MI Health Link 1915(c) waiver participants. In addition, for each ICO, MDHHS interviews at least five enrollees in their homes or telephonically. Qualified reviewers examine enrollment, assessment data, nursing facility level of care determinations, the Individual Integrated Care and Supports Plan (IICSP) and care planning process, and reassessment data to assure compliance with program standards and requirements.

For enrollees participating in arrangements that support self-determination, every self-determination budget is reviewed by at least two entities: ICOs and fiscal intermediaries. Fiscal intermediaries submit monthly reports for each enrollee directed budget. An additional sampling component is part of the service plan approval and authorization review for cases involving individual budgeting. This has been included to assure compliance with policies and guidelines associated with arrangemets that support self-determination.

MDHHS does a review of a representative random sample of all waiver enrollees during the quality assurance review and if an enrollee participating in an arrangement that supports self-determination falls into the random sample, the enrollee's file is reviewed as part of that sample. The reviewers are trained in the requirements of self-determination and assure all requirements are met within the case record. When requirements are not met, corrective action is required.

MDHHS requires the fiscal intermediary to send monthly monitoring reports to both the enrollee and the ICO. These reports identify the planned services and budget, the paid services, and a comparison of each. When budgets have more than a 10% discrepancy, MDHHS requires the ICO to discuss this discrepancy with the enrollee to determine the root cause and identify methods of remediation as necessary.

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:

Every twelve months or upon a significant change in the enrollee's condition or at the request of the enrollee.

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 ICO.

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.

a) Entities responsible for implementation and monitoring are the ICO Care Coordinator, the LTSS Supports Coordinator if applicable, the enrollee to the extent they choose, and the enrollee's support network, as appropriate. MDHHS conducts quality assurance reviews to ensure appropriate implementation and monitoring of the Individual Integrated Care and Supports Plan (IICSP)

b) and c) Within thirty days of service implementation, MDHHS requires ICO Care Coordinators to contact each enrollee to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, ICOs take corrective action to resolve problems and issues. MDHHS also requires the ICO Care Coordinator to contact each enrollee in person or by telephone at least monthly (more frequently as needed) to ensure delivery of services continues as planned, the enrollee is satisfied with service delivery, and to determine any change in needs since the previous contact. If a back-up plan was required during the month, the ICO Care Coordinator will discuss the effectiveness of the plan and whether any changes are necessary. If the enrollee is not satisfied with a provider, the enrollee is given the choice to change providers. The ICO Care Coordinator or LTSS Supports Coordinators also confirms all non-waiver services are being conducted and the enrollee has access to any additional resources required. Enrollees and their families are provided with telephone numbers to contact ICOs and care/supports coordinators at any time when new needs emerge that require interventions and additional supports and services. Enrollees participating in arrangements that support self-determination and their support network also monitor the care and IICSP including monitoring service budget utilization, time sheets of providers, and authorization for services to ensure services designated in the IICSP have been accessed and provided in accordance with the plan. Participants and families are also educated on health and welfare and are encouraged to call their ICO Care Coordinator or LTSS Supports Coordinator in the event of a potential critical incident.

Reassessments are required at least every twelve months. During the reassessment, the back-up plans and health and safety of the enrollee are reviewed and altered as needed.

If any problems are discovered during monitoring, issues are addressed immediately. If services are not being implemented as outlined in the service plan or the enrollee's needs are not being met, a corrective action is developed between the enrollee and ICO to remedy the situation. The enrollee must approve all changes in the IICSP, and is provided the appropriate notice of action when required. The corrective action could include changing providers, increasing or decreasing the amount of care or rescheduling services.

If any critical incidents are suspected during the monitoring process or are reported by the enrollee, family, service provider, or any other individual, the ICO will act immediately to ensure the health and welfare of the enrollee. Options to protect the enrollee will be presented and discussed by the ICO, the enrollee and the enrollee's chosen allies. Any revisions to the service plan will be implemented immediately and followed-up on regularly.

ICOs are responsible for on-going monitoring of IICSP implementation and of direct service providers. ICOs conduct a formal administrative review annually according to the MDHHS plan for monitoring of direct service providers.

MDHHS examines ICO monitoring activities and reports during its quality assurance review process to ensure that monitoring activities are being conducted, service issues and problems are being resolved appropriately and timely, and any other concerns regarding a specific provider are identified.

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:*

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 enrollees whose IICSP addresses their assessed health and safety risks. Numerator: Number of enrollees whose IICSP addresses their assessed health and safety risks. Denominator: Number of enrollee files reviewed.

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

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 =

		Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICOs	☒ **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 enrollees whose IICSP includes services and supports that align with their assessed needs. Numerator: Number of enrollees whose IICSP includes services and supports that align with their assessed needs. Denominator: Number of enrollee files reviewed.

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

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 = Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICOs	☒ **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 & percent of enrollees with an individualized contingency/back-up plan addressing caregiver absences, severe weather, fire/other emergencies. Numerator: Number of enrollees with an individualized contingency/back-up plan that addresses caregiver absences, severe weather, fire/other emergencies. Denominator:Number of enrollee files reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
record review on or off-site

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 =

		proportionate random sample 95% confidence level with +/- 5% margin of error.
☒ **Other** Specify: ICO	☒ **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 & percent of enrollees w/IICSPs that include at least one individualized personal goal (e.g. losing weight, engaging in a hobby, reducing specific symptoms, seeking out social contact) Numerator: Number of enrollees w/IICSPs that include at least one individualized personal goal. Denominator: Number of enrollee files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews on or off-site; enrollee interviews

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 = Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICO	☒ **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 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.

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 enrollee IICSPs that are updated as the enrollee's needs change. Numerator: Number of enrollee IICSPs that are updated as the enrollee's needs change. Denominator: Number of enrollees who had needs change.

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

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 = Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☐ **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 enrollee IICSPs that are updated within 12 months of last IICSP. Numerator: Number of enrollee IICSPs that are updated within 12 months of last IICSP. Denominator: Number of enrollee files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site record reviews or off-site record reviews

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 =

		Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICOs	☒ **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: 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 enrollees who had IICSPs in which services and supports are provided as specified in the IICSP, including type, scope, amount, duration, and frequency. Numerator: Number of enrolleess who had IICSPs in which services and supports are provided as specified in the IICSP. Denominator: Number of enrollee files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews on-site or off-site; home visits

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 = Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICOs	☒ **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:

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 enrollees whose IICSPs document choice was offered among waiver services. Numerator: Number of enrollees whose IICSPs document choice was offered among waiver services. Denominator: All enrollee files reviewed.

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

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 = Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☐ **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 enrollees with IICSP containing documented discussion of their rights and choices for providers. Numerator: Number of enrollees with IICSP containing documented discussion of their rights and choices for providers. Denominator: All enrollee files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, on-site or off-site; home visits; other reports

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

		Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICO	☒ **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.

1. ICOs have monthly contacts with enrollees to ensure the IICSP addresses the enrollee's assessed needs, including risk management planning. Additionally, this review ensures ICO Care Coordinators or LTSS Supports Coordinators include changes noted during enrollee assessments and reassessments into the IICSP.

2. MDHHS requires a person-centered planning process for the development of the IICSP. Each ICO trains its staff and enrollees using MDHHS established protocols. The ICO maintains staff training records on attendance by date and total number of attendees, topics, and training evaluations. During the quality assurance review process, MDHHS validates that the ICO uses the person-centered planning process according to the guidelines. Enrollee training is documented in the case record and reviewed during the quality assurance review process.

3. ICO Care Coordinators and LTSS Supports Coordinators assist enrollees in identifying risks during the person-centered planning process and assure that the IICSP includes risk management planning. The IICSP identifies enrollee risks with strategies and plans to reduce or eliminate risk as approved by enrollees. ICO Care Coordinators monitor risk management strategies on an on-going basis and evaluate their effectiveness.

4. At the direction of MDHHS, ICOs survey enrollees annually to ensure enrollees receive needed supports and services, successfully implement back-up plans, are satisfied with equipment, are satisfied with treatment by workers and other service providers, and have choice and control through the person-centered planning process. ICOs use the enrollee surveys as one method to determine that enrollees actually receive services as planned. ICOs follow up with enrollees to correct any problems with service delivery. MDHHS reviews the response rate, summary of results, analysis of strengths, limitations, barriers to implementation, and ask to find out what ICOs did with the information they obtained during the survey and how it changed their program. MDHHS also analyzes the data for any trends or possible system improvements that can be made locally or statewide.

5. During the quality assurance review process, qualified reviewers perform annual IICSP and case record reviews on a random sample of enrollees to ensure IICSP development occurs according to MDHHS contract requirements, policy, and procedures. The quality assurance review process ensures the ICO authorizes and approves services in the IICSP. Home visits confirm that providers furnish services according to the IICSP and enrollee preferences.

6. The ICO Care Coordinators validate that providers render services as planned during initial service implementation and on a monthly basis with enrollees. MDHHS also requires ICO staff to contact enrollees at least monthly to ensure delivery of services as planned and enrollee satisfaction with services. Qualified reviewers examine these activities as part of the quality assurance review process. This includes verification that the ICO honored the enrollees' choices of service setting (signed freedom of choice form) and the type of services rendered, and also ensured choice of service providers. Qualified reviewers analyze findings to ensure that enrollees receive supports and services consistent with identified needs and preferences. Findings are compiled into written corrective action and quality indicator outcome reports.

7. MDHHS requires the self-determination fiscal intermediary to send monthly monitoring reports to both the enrollee and the ICO. These reports identify the planned services and budget, the paid services, and a comparison of each. When budgets have more than a 10% discrepancy, MDHHS requires the ICO to discuss this discrepancy with the self-determination enrollee to determine the root cause and identify methods of remediation as necessary. When an enrollee who chose the self-determination option is randomly selected for the quality assurance process, the qualified reviewers assure the proper use of this, and other self-determination processes while reviewing the record.
8. MDHHS will contract with a vendor to complete a HCBS CAHPS survey to gather data related to the enrollee experience with HCBS services.

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.

Qualified reviewers or MDHHS staff may also provide technical assistance to ICO staff when the reviewers note deficiencies during the quality assurance review. During the quality assurance review process, qualified reviewers perform annual IICSP & case record reviews on a random sample of enrollees to ensure care coordinators conduct IICSP development according to MDHHS contract requirements, policy, and procedures.During this review, if any enrollee plan of service does not: include services or supports that align with their assessed needs; address health and safety risks; include goals and preferences; or are not developed in accordance with policies & procedures, the ICO must redesign the IICSP within two weeks. This may require another person-centered planning meeting with the enrollee & whomever else the enrollee wants included. The ICO must provide enough notice so that everyone can attend if they choose. Prior to implementing the new IICSP, the enrollee must provide approval. MDHHS will monitor the revised IICSP to ensure all requirements have been met.
ICOs are required to update the IICSP within twelve months of the previous plan of service, or as needs change. If any enrollee service plans are not updated as required & the situation has not already been remediated, MDHHS will require the ICO to conduct a face-to-face assessment & update the enrollee's IICSP as necessary within two weeks. The ICO must also provide MDHHS with documentation that demonstrates that these updates have been made.
Choice is extremely important in the MI Health Link HCBS waiver program. During the quality assurance review process, if a waiver enrollee record does not contain a completed & signed freedom of choice form indicating preference to be in the MHL program the ICO will be required to obtain a complete and signed form specifying that the enrollee was offered a choice between institutional care & waiver services, & chose the MI Health Link HCBS waiver program. The form must be sent to MDHHS for proof of documentation & must be added to the enrollee's Integrated Care Bridge Record. If a waiver enrollee's record does not indicate choice was offered among waiver services or providers, the ICO will be required to provide information to the enrollee offering all waiver services & providers. The ICO must work with the enrollee to provide services they choose when a need exists & choice of providers when possible. Documentation must be provided to MDHHS & stored in the enrollee record that proves the enrollee was given a choice among services & providers. For initial approval for participation in the MHL HCBS waiver, MDHHS will assure the MHL HCBS Application Form has been signed, indicating choice of program, services, & providers have been offered & selected by the applicant. Enrollment in the MHL HCBS waiver will be pended until this form is completed.

ICOs submit provider monitoring reports to MDHHS, who in turn reviews the reports as part of the quality assurance activities & may request additional information based on performance. MDHHS may request ICOs take action with their providers if they are concerned about their performance or interaction with enrollees. If necessary, MDHHS may request further corrective action plans to resolve outstanding issues.
Enrollee surveys are conducted, and data is aggregated and analyzed by the ICOs and MDHHS. MDHHS reviews the response rate, summary of results, analysis of strengths, limitations, other issues, barriers to implementation and inquire about what ICOs did with the information they obtained from the survey and how it changed their program. MDHHS also analyzes the data for any trends or possible system improvements that can be made locally or statewide.
After completing the quality assurance reviews, MDHHS conducts an exit conference with the ICO staff. During the exit conference, the ICO is provided with a summary report of findings including any findings that require immediate remediation. The immediate remediation is due within 72 hours. MDHHS also compiles quality assurance review findings from annual audits, critical incident reviews and provider monitoring reviews into draft reports that are sent to the ICO. The ICO will receive a rebuttal period of 5 business days in which they can submit documentation not previously reviewed to support reconsideration of findings. MDHHS will make any revisions to the draft reports as appropriate and the ICO will receive a final report. When the final report indicates a need for corrective action, the ICO has 30 calendar days to respond with a corrective action plan (CAP) utilizing the MDHHS template.
Corrective action plans should demonstrate that the ICO has:
1.Analyzed all non-evident findings and determined possible causes;
2.Developed a remediation strategy, including timelines, that address and resolve the problems; and
3.Planned ongoing monitoring of remediation activities and performance.
MDHHS will review the CAP and will accept or request a resubmission. If accepted, the plan will have 90 calendar days to implement. If a resubmission is requested, the plan will be required to update the CAP and resubmit within 7 calendar days. After second submission, if the CAP is not accepted, MDHHS will execute sanctions in accordance with the Three Way Contract until a submitted CAP is accepted. MDHHS may request an independent validation audit in accordance with MDHHS and CMS requirements.
MDHHS will monitor the implementation of the CAP. ICOs are required to provide evidence of their remediation

strategy by submitting documentation to MDHHS following the implementation phase utilizing MDHHS template. This documentation might include training materials, revised policies and procedures, information from staff meetings or case record documentation to support the corrective action plan has been implemented. Ongoing monitoring will occur as needed.

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: ICOs	☒ **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.

This option, called Self-Determination in Michigan, provides enrollees with the option to direct and control their waiver services through an individual budget. Enrollees are supported in directing the use of the funds comprising their respective individual budgets for services designated in Appendix C. ICO Care Coordinators or LTSS Supports Coordinators work with enrollees to develop and revise individual budgets. Enrollees have the option of appointing a representative to assist them with directing their supports and services and obtaining additional assistance through participation in a peer support group.

ICOs directly provide care coordination and hold contracts with providers of services that conform to federal regulations. As enrollees exercise employer authority, each provider furnishing services is required to execute a Medicaid Provider Agreement with the ICO that conforms to the requirements of 42 CFR 431.107. Guidance for self-determination is provided through MDHHS, training and technical assistance, technical advisories and other documents.

(a) The nature of the opportunities afforded to enrollees:

Waiver enrollees have opportunities for both employer authority and budget authority. Enrollees may elect one or both authorities, and can direct a single service or all of their services for which enrollee direction is an option. The enrollee may direct the budget and directly contract with qualified chosen providers. The individual budget is transferred to a fiscal intermediary (this is the MDHHS term for an agency that provides financial management services), which administers the funds and makes payment upon enrollee authorization.

Two options available for enrollees choosing to directly employ workers are the Choice Voucher System and Agency with Choice. Through the Choice Voucher System, the enrollee is the common law employer and delegates performance of the fiscal or employer agency functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The enrollee directly recruits, hires and manages employees. Detailed guidance to ICOs is provided in the Choice Voucher System technical advisory being developed by MDHHS. In the Agency with Choice model, enrollees may contract with an Agency with Choice and split the employer duties with the agency. The enrollee 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 enrollee. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to ICOs is provided in the Agency with Choice technical advisory being developed by MDHHS. An enrollee may select one or both options. For example, an enrollee may want to use the Choice Voucher System to directly employ a good friend to provide expanded community living supports during the week and Agency with Choice to provide expanded community living supports on the weekends.

(b) How enrollees may take advantage of these opportunities:

Information on self-determination is provided to all MI Health Link HCBS enrollees. Enrollees interested in arrangements that support self-determination start the process by informing their ICO Care Coordinator or LTSS Supports Coordinator of their interest. The enrollees are given information regarding the responsibilities, liabilities and benefits of self-determination prior to the person-centered planning process. An IICSP is developed through this process with the enrollee, ICO Care Coordinator and/or LTSS Supports Coordinator, and allies chosen by the enrollee. The service plan includes MI Health Link HCBS waiver services needed by and appropriate for the enrollee. An individual budget is developed based on the services and supports identified in the IICSP and must be sufficient to implement the IICSP. The enrollee selects service providers and has the ability to act as the employer of personal assistants. ICOs provide many options for enrollees to obtain assistance and support in implementing their arrangements.

(c) The entities that support individuals who direct their services and the supports that they provide:

ICOs are the primary entities that support individuals who direct their own services. The care coordination function is provided by the ICO Care Coordinator or LTSS Supports Coordinator. The ICO Care Coordinator or LTSS Supports Coordinator is responsible for working with self-determination enrollees through the person-centered planning process to develop an IICSP and an individual budget. The ICO Care Coordinator responsible for obtaining authorization of and monitoring the budget and plan. The ICO Care Coordinator, or LTSS Supports Coordinator, and enrollee share responsibility for assuring that enrollees receive the services to which they are entitled and that the arrangements are implemented smoothly.

Through its contract with MDHHS, each ICO is required to offer information and education on participant direction to

enrollees. Each ICO also offers support to enrollees in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Each ICO is required to contract with fiscal intermediaries to provide financial management services. The fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements.

The fiscal intermediary has four basic areas of performance:

1) Function as the employer agent for enrollees directly employing workers to assure compliance with payroll tax and insurance requirements;

2) Ensure compliance with requirements related to management of public funds, the direct employment of workers by enrollees;

3) Facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to the enrollee and agency; and

4) Offer supportive services to enable enrollees to self-determine and direct the services and supports they need.

(d) Other relevant information about the waiver's approach to enrollee direction:

MDHHS supports a variety of methods for participant direction so that arrangements can be specifically tailored to meet the enrollee's needs and preferences.

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:

Adult Foster Care and Homes for the Aged

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

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.

The ICOs are responsible for providing information about participant direction opportunities. General information about arrangements that support self-determination is made available to all waiver enrollees (new and current) by providing them with a general brochure and with directions how to obtain more detailed information. When a person receiving waiver services expresses interest in participating in arrangements that support self-determination, the ICO Care Coordinator, LTSS Supports Coordinator, or other qualified provider as selected by the enrollee, who has specific training and expertise in the various options available, will assist the enrollee in gaining an understanding about self-determination arrangements and how those might work for the enrollee.

Specific options and concerns such as the benefits of enrollee-direction, enrollee responsibilities and potential liabilities are addressed through the person-centered planning process. Each enrollee develops an IICSP through the person-centered planning process, which involves his or her allies and the ICO Care Coordinator and LTSS Supports Coordinator as applicable. The IICSP developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. Guidelines for person-centered planning and self-determination requires that enrollee health and safety concerns be addressed.

MDHHS provides support and technical guidance to ICOs for developing regional capacity and with implementing options for participant direction.

(b)The entity or entities responsible for furnishing this information:

The ICOs are responsible for disseminating this information to enrollees, and the ICO Care Coordinators and/or LTSS Supports Coordinators primarily carry out this function. In addition, MDHHS staff provides information and training to provider agencies, advocates and enrollees on self-determination materials.

(c) How and when this information is provided on a timely basis:

This information is provided throughout the enrollee's involvement with the ICO. It starts from the time that the enrollee approaches the ICO for waiver services and is provided with information regarding options for participant direction. Enrollees are to be provided with information about the principles of self-determination and the possibilities, models and arrangements involved. The person-centered planning 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 enrollee concerns and needs are addressed. Self-determination arrangements begin when the ICO and the enrollee reach agreement on a the IICSP, the funding authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each enrollee (or the enrollee's representative) who chooses to direct his or her supports and services signs a Self-Determination Agreement with the ICO that clearly defines the duties and responsibilities of the parties.

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:

Informal supports, such as non-legal representatives freely chosen by adult enrollees, can be an important resource for the enrollee. These individuals can include agents designated under a power of attorney or other identified persons participating in the person-centered planning process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the enrollee. Additionally, the ICO Care Coordinator contacts the enrollee on a monthly basis and ensures the enrollee's representative is not authorizing self-determined services that do not fit the enrollee's preferences or do not promote achievement of the goals contained in the enrollee's IICSP. The ICO Care Coordinator or LTSS Supports Coordinator assures the enrollee's IICSP promotes independence and community inclusion and the representative does not act in a manner that conflicts with the enrollee's stated interests. In the event the representative is working counter to the enrollees interests, the ICO Care Coordinator or LTSS Supports Coordinator is authorized to address the issue and work with the enrollee to find an appropriate resolution.

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
Private Duty Nursing	☒	☒
Fiscal Intermediary	☒	☒
Non-Medical Transportation	☒	☒
Chore Services	☒	☒
Expanded Community Living Supports	☒	☒
Preventive Nursing Services	☒	☒
Respite	☒	☒
Environmental Modifications	☒	☒

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:

ICOs contract with private entities to furnish Fiscal Intermediary Services. ICOs must contract with at least one fiscal intermediary that meets the service standards defined in the Choice Voucher System guidance.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities contract with ICOs and are compensated by the ICO as a MI Health Link HCBS service through the enrollee's individual budget.

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:

Conducts background checks on potential self-determined employees and verifies employees receive required provider training.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement**

with the Medicaid agency or operating agency

☒ **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) The fiscal intermediary provides monthly budget reports to the ICO and enrollee. The ICO Care Coordinator ensures that performance and integrity of the fiscal intermediary are appropriate and acceptable to the enrollee through person-centered planning meetings and monthly contacts with the enrollee, and follows up with the enrollee when budget reports indicate that budgets are more than 10 percent over or under the approved amount.

b) ICOs are responsible for monitoring the performance of fiscal intermediaries.

c) ICOs review performance of fiscal intermediaries annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **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
Private Duty Nursing	☐
Fiscal Intermediary	☐
Non-Medical Transportation	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Chore Services	☐
Community Transition Services (terminated effective 04/24/2019)	☐
Personal Emergency Response System	☐
Adaptive Medical Equipment and Supplies	☐
Home Delivered Meals	☐
Adult Day Program	☐
Expanded Community Living Supports	☐
Preventive Nursing Services	☐
Assistive Technology	☐
Respite	☐
Environmental Modifications	☐

☒ **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:

ICOs employ care coordinators who carry out the ICO's responsibility to work with enrollees through the person-centered planning process. ICO Care Coordinators work with enrollees to develop an Individual Integrated Care and Supports Plan (IICSP) and an individual budget, to obtain authorization of the budget and the IICSP, and to monitor the plan, budget and arrangements made as part of the plan. The care coordinators make sure that enrollees get the services to which they are entitled and the arrangements are implemented smoothly. MDHHS, or other individuals chosen by MDHHS, will train ICO Care Coordinators in the details and processes related to arrangements that support self-determination.

MDHHS does not have a different review process for enrollees who choose arrangements that support self-determination. During the review process, MDHHS looks at each record selected to ensure the IICSP is appropriate and payments to providers for services delivered are made in accordance with the approved IICSP. While enrollees participating in arrangements that support self-determination may use a different funding mechanism, and the quality assurance review team may have to look at different documentation to verify the appropriateness, MDHHS still ensures the appropriateness of budgets, plans, and payments within the same protocol used for all other records reviewed.

MDHHS also reviews all policies, procedures, and forms used for self-determination as developed and during the quality assurance review process. MDHHS assesses the performance of ICOs on an annual basis using a survey audit and a reporting process.

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 variety of options for independent advocacy are available in self-determination. These options include utilizing a network of allies in the person-centered planning process and obtaining the assistance of the ICO Care Coordinator. Independent advocacy may be furnished by an individual or organization of the enrollee's choice that does not also provide State Plan or waiver services to the enrollee, conduct assessments, engage in other waiver monitoring, oversight, or financial functions that would directly affect the participant. If the enrollee does not know who to contact, the ICO Care Coordinator will help the enrollee find some options from which to choose. The independent advocate may assist the enrollee in making informed decisions about options that will work for him or her, are related to his or her needs and desires, and appropriately reflect the enrollee's particular circumstances; explore availability of supports and services, housing, employment, and provide links to those resources as necessary; offer training on practical skills to help the enrollee to live independently, including assistance with recruiting, hiring, and managing service providers under arrangements that support self-determination. If the enrollee utilizes an independent advocate, the ICO Care Coordinator will have less of a role in these areas, though will still be involved in the enrollee's case to provide other required care coordination functions.

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 enrollee has the choice at any time to modify or terminate his or her arrangements that support self-determination. The most effective method for making changes is the person-centered planning process in which individuals chosen by the enrollee work with the enrollee and the ICO Care Coordinator or LTSS Supports Coordinator to identify challenges and address problems that may be interfering with the success of an arrangement. The decision of an enrollee to terminate participant direction does not alter the supports and services identified in the Individual Integrated Care and Supports Plan (IICSP). In that event, the ICO has an obligation to assume responsibility for assuring the provision of those services through its network of contracted provider agencies.

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.

An ICO may involuntarily terminate participant direction by a person when the health and welfare of the enrollee is in jeopardy or other serious problems are resulting from the enrollee's failure in directing services and supports. Prior to the ICO terminating an agreement, and unless it is not feasible, the ICO informs the enrollee in writing of the issues that have led to the decision to consider altering or discontinuing the arrangement and provides an opportunity for problem resolution. Typically, the person-centered planning process is used to address the issues, with termination being the option of choice if other mutually agreeable solutions cannot be found. ICOs provide notice to enrollees when it is necessary to terminate the arrangements that support self-determination. In most cases, ICOs provide advanced notice. However, if waiting to terminate these arrangements places the enrollee in jeopardy, the arrangements are terminated immediately and a notice of denial of medical coverage is provided. ICOs also provide information on how to request a Medicaid Fair Hearing, including the request form and a self-addressed, postage paid envelope.

In any instance of discontinuation or alteration of a self-determination arrangement, grievance procedures are available to address and resolve the issues and can be conducted in conjunction with the Medicaid Fair Hearings process. ICOs must inform the enrollee about their right to use this process whenever there is a need to resolve an issue, or provide notice to the enrollee. The decision of the ICO to terminate a self-determination arrangement does not alter the services and supports identified in the IICSP. In that event, the ICO has an obligation to take over responsibility for providing those services through its network of contracted provider agencies.

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		792
Year 2		808
Year 3		825
Year 4		841
Year 5		858

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

In the Agency with Choice model, enrollees serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (or otherwise referred to here as AWC provider) serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing worker's compensation insurance). In the Agency with Choice model, enrollees may get help with selecting their workers (for example, the AWC provider may have a pool of workers available for consideration by enrollees). The AWC provider may also provide back-up workers when the enrollee's regular worker is not available. Like traditional staffing agencies, the AWC provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that enrollees cannot provide when directly employing workers. The Agency with Choice model is also an important option for enrollees who do not want to directly employ workers or who want to gradually transition into direct employment. Under the Agency with Choice model, the enrollee maintains as much authority and control over the employment process as he or she desires.

AWC providers must not be fiscal intermediaries, Prepaid Inpatient Health Plans, Community Mental Health Service Programs (CMHSPs), ICOs, and affiliated agencies or subsidiaries. AWC providers must be staffing agencies that choose to offer Agency with Choice services and operate as a business, meets any AWC provider qualification requirements, and holds proper professional and business liability insurance. The AWC provider, the enrollee, and each hired worker must have a three-party agreement that clearly describes the roles and responsibilities of each party.

☒ **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:

The fiscal intermediary is responsible for conducting criminal history reviews for directly employed personal assistance providers. The cost is built into their monthly fee.

☒ **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:

N/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**

- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

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*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the state's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

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 individual budget is based on the Individual Integrated Care and Supports Plan (IICSP) developed through the person-centered planning process. The budget is created by the enrollee, the ICO Care Coordinator, and LTSS Supports Coordinator, if one is used. Funding must be sufficient to purchase the supports and services identified in the IICSP.

A simple methodology using reliable cost estimating information is used to develop the budget. Each budget is the sum of the units of services multiplied by the time period covered, multiplied by the rate for the service as authorized by the ICO. Due to the variations in economic conditions in this geographically diverse state, the state does not set a uniform rate for each service. This formula allows each enrollee and ICO to negotiate rates for providers. Typically, when an existing IICSP is transitioned to an enrollee-directed set of service arrangements, the overall budget is not more than the costs of delivering the services under the previous provider-driven set of service arrangements.

An ICO may use a pre-determined amount based on the local usual and customary waiver costs for the identified services as a starting point for budget development. This amount is based on historic utilization of funds by that enrollee. If the enrollee is new to the system, then the pre-determined amount is based upon the average cost of services for individuals who have comparable needs and circumstances. Where rates for services are negotiated, the rates must be sufficient for the enrollee to access an adequate array of qualified providers. If rates are determined by the enrollee to be insufficient, the ICO reviews the budget with the enrollee using a person-centered planning process.

On behalf of the ICO, the ICO Care Coordinator authorizes the funds in an individual budget. The ICO Care Coodinator must share the cost estimating information with the enrollee and his or her allies. The target may be exceeded for any individual, but the Care Coordinator typically obtains approval from a higher level of supervision within the ICO for those higher increments of cost. The ICO is responsible for monitoring the implementation of the budget and making adjustments as necessary to ensure that the budget is sufficient to accomplish the plan and maintain the health and welfare of the enrollee. To this end, the fiscal intermediary provides monthly reports on budget utilization to the enrollee and the ICO. The ICO Care Coordinator is expected to review the status of each assigned enrollee's individual monthly budget utilization report and confers with the enrollee as necessary to support success with implementing the budget and obtaining needed services.

Budget development occurs during the person-centered planning process and is intended to involve the enrollee's chosen family members and allies. Planning for supports and services precedes the development of the individual budget so that needs and preferences can be accounted for in IICSP development without arbitrarily restricting options and preferences due to cost considerations. An individual budget is not authorized until both the enrollee and the ICO have agreed to the amount and its use. In the event that the enrollee is not satisfied with the authorized individual budget, the person-centered planning process may be reconvened. If the person-centered planning process is not acceptable, the enrollee may utilize the internal grievance procedure of the waiver agency or file for a Medicaid Fair Hearing.

Guidance provided to enrollees by ICOs:

MDHHS uses a retrospective zero-based method for developing an individual budget. This means the amount of the individual budget is determined by costing out the services and supports in the IICSP, after the development of an IICSP meeting the individual's needs and goals. Budgeting worksheets are provided by MDHHS to uniformly calculate budgets. The enrollee and the ICO agree to the amounts of the individual budget before the ICO authorizes it for use by the enrollee. The ICO explores options in terms of preferences as well as costs with the enrollee with the aim for arrangements that improve value.

The ICO ensures that all waiver enrollees have a meaningful copy of the IICSP and the individual budget. The ICO also ensures the provision of a monthly spending report based on the individual budget and services used. The ICO follows up with enrollees when spending has a variance of 10% above or below the total monthly budget.

The enrollee and his or her allies are fully involved in the budget development process and the enrollee understands the options and limitations for using the funds in the individual budget to obtain the services and supports in the service plan. The ICO Care Coordinator informs enrollees in writing of the options for, and

limitations on, flexibility and portability. ICOs must inform enrollees as to how, when, and what kind of changes they can make to their individual budget without support coordinator approval and when such changes require approval.

Fair Hearing Process:

The ICO would send the enrollee a notice of denial of medical coverage if their request for a budget adjustment was denied or reduced. These letters give instructions on how to file an appeal and request a Fair Hearing. Information on how to file an appeal is also included in the MI Health Link Enrollee Handbook.

Each ICO has its own internal grievance process that the enrollee must use before they can request a Fair Hearing.

Public Information:

This information is provided to all enrollees who choose self-direction. Any enrollee could request the information from the ICO.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Materials provided by the ICO include written information on the development of the individual budget. During the planning process, an enrollee is provided clear information and an explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the enrollee during individual budget implementation.

The enrollee's ICO Care Coordinator or LTSS Supports Coordinator provides assistance to the enrollee in understanding the budget and how to utilize it. The enrollee may seek an adjustment to the individual budget by requesting this from their ICO Care Coordinator or LTSS Supports Coordinator. The ICO Care Coordinator or LTSS Supports Coordinator assists the individual in convening a meeting that includes the enrollee's chosen family members and allies, and assures facilitation of a person-centered planning process to review and reconsider the budget. A change in the budget is not effective unless the enrollee and the ICO authorize the change.

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:

Guidance provided to enrollees outlines the options for flexible application of the individual budget, with the expectation that the use of budgeted funds are to acquire and direct the provision of services and supports authorized in the IICSP. These options include:

a. Service authorizations allow flexibility across time periods (e.g. month, quarter, etc.) so that enrollees may schedule providers to meet their needs according to their preferences and individual circumstances. In situations where actual utilization is not exactly the same as initially planned utilization, no notification is necessary on the part of the enrollee. The enrollee must be able to shift funds between line items as long as the funding pays for the supports and services identified in the IICSP. Enrollees may negotiate rates with providers that are different from the rates that the budget is based upon, so long as the enrollee remains within the overall framework of their respective budgets. These utilization patterns and actual cost differences appear in monthly budget reports provided by the fiscal intermediary. The ICO Care Coordinator is expected to review monthly budget reports and interact with the enrollee to assure that implementation is occurring successfully. When an enrollee is intending to significantly modify the relative amount of services in comparison to their plan, they are expected to inform the fiscal intermediary and the ICO Care Coordinator.

b. When a enrollee wants to significantly alter the goals and objectives in the service plan or obtain authorization of a new service that effects allocation of funds within the budget, the adjustment must be considered through the person-centered planning process and mutually agreed upon by the ICO and enrollee, even if the overall budget amount does not change. The changes are reflected in the IICSP and individual budget and appended to the enrollee's Self-Determination Agreement.

c. When the enrollee is not satisfied with the IICSP and individual budget that result from the person-centered planning process, the enrollee may reconvene a person-centered planning meeting, file a Fair Hearing request, or utilize an informal grievance procedure offered by the ICO.

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 fiscal intermediary provides monthly reports to both the enrollee and the ICO and flags over or under expenditures of ten percent in any line item in the budget. This procedure helps ensure that the parties have sufficient notice to take action to manage an over expenditure before the budget is depleted and to avoid any threats to the enrollee's health and welfare that may be indicated by an under expenditure. The ICO Care Coordinator is responsible for monitoring the reports and the arrangements to ensure that the enrollee is obtaining the supports and services identified in the IICSP. Any party can use the report to convene a person-centered planning meeting to address an issue related to expenditures.

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.

Enrollees have the right to a Fair Hearing when they are denied eligibility (for the MI Health Link HCBS waiver only, the MI Health Link 1915(b) waiver, or Medicaid in general), denied choice of providers, or when services have been denied, suspended, reduced or terminated. When denials, suspensions, reductions, or terminations occur, ICOs will provide the enrollee with a notice of denial of medical coverage. This notice of denial of medical coverage is a single, integrated form for Appeals related to Medicare and Medicaid supports and services or providers and must include the following components:
• The action the ICO has taken or intends to take;
• The reasons for the action explained in terms that are easy for the enrollee to understand;
• The citation to the supporting regulations;
• The enrollee's, provider's or authorized representative's right to file an internal Appeal with the ICO and that exhaustion of the ICO's internal Appeal processes is a prerequisite to filing an External Appeal to Medicare for a Medicare service or filing an external review (Patient's Right to Independent Review Act (PRIRA)) with DIFS for a Medicaid service;
• Beginning 1, 2018, all internal appeals for Medicaid service denials must be made to the entity taking the action prior to filing an appeal with Michigan Office of Administrative Hearings and Rules (MOAHR).
• Procedures for exercising enrollee's rights to appeal;
• The enrollee's right to request a State Fair Hearing in accordance with MCL 400.9,
• Circumstances under which expedited resolution is available and how to request it;
• The enrollee's right to request an independent review of a Medicaid service with the DIFS in the implementation of PRIRA, MCL 550.1901-1929; and
• If applicable, the enrollee's rights to have benefits continue pending the resolution of the appeal, and the circumstances under which the enrollee may be required to pay the costs of these services.

Internal or Initial Appeals for Medicaid service denials will be made to the ICO. If the ICO's decision is sustained in the Initial Appeal, the enrollee may appeal to MOAHR as long as it is within the 120 days of the notice of denial of medical coverage. All Appeals must be resolved by the ICO as expeditiously as the enrollee's condition requires, but always within 30 calendar days of the request for standard appeals, and within 72 hours of the request for expedited appeals. This timeframe may be extended up to 14 days if the party or parties can show there is a need for the delay and it is in the enrollee's best interest. MOAHR will resolve appeals as expeditiously as the enrollee's condition requires, but always within 90 calendar days of the received request.

The ICO must continue to provide benefits for all prior approved benefits (excluding Medicare Part D) that are terminated or changed pending ICO Internal Appeals. For all appeals filed with MOAHR, ICOs must continue to cover benefits for requests received within 10 calendar days of the notice of denial of medical coverage. In circumstances where the time for a standard appeal is too long and may seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, the ICO or the enrollee's provider may request an Expedited Appeal. If the Expedited Appeal is denied, the appeal request is moved to the standard appeal timeframe and attempts must be made to notify the enrollee immediately and also provide the enrollee with written notice of the denial within two calendar days.

All appeal decisions must be in writing and must include, but not be limited to, the decision that was reached and the date of the decision. If the appeal decision is not entirely in favor of the enrollee, the following information must be included in the notification to the enrollee: 1) the right to request a State Fair Hearing and how to do so within the 120 calendar days timeframe, 2) the right to receive benefits if the Internal Appeal was received within 10 calendar days of the notice of denial of medical coverage, and 3) the right to request external review through PRIRA and DIFS and how to do so.

If an appeal involves either a Medicaid only or Medicare/Medicaid overlapping benefit with either the ICO or PIHP, the enrollee must ask for an internal appeal with the ICO before they may ask for the state fair hearing. For appeals involving Medicare and Medicaid overlapping benefits, enrollees may file an appeal through either the Medicare or Medicaid appeals processes or both after exhausting the internal ICO appeals process.

If an appeal involves an ICO Medicaid only benefit and the enrollee chooses to appeal through the Michigan Department of Financial and Insurance Services, Patient Right to Independent Review Act, external review, the enrollee must first exhaust the ICO appeal process.

Initial appeals for Medicare service denials, reductions and terminations will be made to the ICOs; sustained decisions will be auto-forwarded to the Medicare Independent Review Entity (IRE). Enrollees will be able to request a hearing before an Office of Medicare Hearings and Appeals (OMHA) administrative law judge for decisions sustained by the IRE.

Payments for services covered during a pending appeal will not be recouped based on the outcome of the appeal.

Additionally, the Enrollee Handbook (or Member Handbook, the alternative name) which is provided to enrollees upon enrollment will also describe the entire appeals process including the State Fair Hearing process.

Additional details about fair hearings for Medicare and Medicaid are included in the three-way contract.

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 grievance and appeal process must follow the process described in the Three-Way Contract and MOU, which include the Medicare and Medicaid processes. Requirements under the MI Health Link 1915(b) waiver also must be met.
If an appeal involves either a Medicaid only or Medicare/Medicaid overlapping benefit with either the ICO or PIHP, the enrollee must ask for an internal appeal with the ICO before they may ask for the state fair hearing. For appeals involving Medicare and Medicaid overlapping benefits, enrollees may file an appeal through either the Medicare or Medicaid appeals processes or both after exhausting the internal ICO's appeals process.

If an appeal involves an ICO Medicaid only benefit and the enrollee chooses to appeal through the Michigan Department of Financial and Insurance Services, Patient Right to Independent Review Act, external review, the enrollee must first exhaust the ICO appeal process.

Initial appeals for Medicare service denials, reductions and terminations will be made to the ICOs; sustained decisions will be auto-forwarded to the Medicare Independent Review Entity (IRE). Enrollees will be able to request a hearing before an Office of Medicare Hearings and Appeals (OMHA) administrative law judge for decisions sustained by the IRE.

The Medicaid Fair Hearing process:

Enrollees have the right to a Fair Hearing when they are denied eligibility (for the MI Health Link §1915(b)/(c) waiver only, the MI Health Link 1915(b) waiver, or Medicaid in general), denied choice of providers, or when services have been denied, suspended, reduced or terminated. When denials, suspensions, reductions, or terminations occur, ICOs will provide the enrollee with a notice of denial of medical coverage. This notice of denial of medical coverage is a single, integrated form for Appeals related to Medicare and Medicaid supports and services or providers and must include the following components:
• The action the ICO has taken or intends to take;
• The reasons for the action explained in terms that are easy for the enrollee to understand;
• The citation to the supporting regulations;
• The enrollee’s, provider’s or authorized representative’s right to file an internal Appeal with the ICO and that exhaustion of the ICO’s internal Appeal processes is a prerequisite to filing an External Appeal to Medicare for a Medicare service or filing an external review (Patient’s Right to Independent Review Act (PRIRA)) with DIFS for a Medicaid service;
• The enrollee’s or authorized representative’s right to file an External Appeal with Michigan Office of Administrative Hearings and Rules (MOAHR)after exhaustion of internal appeals with the ICO for Medicaid services.
• Procedures for exercising enrollee’s rights to appeal;
• The enrollee’s right to request a State Fair Hearing in accordance with MCL 400.9,
• Circumstances under which expedited resolution is available and how to request it;
• The enrollee’s right to request an independent review of a Medicaid service with the DIFS in the implementation of PRIRA, MCL 550.1901-1929; and
• If applicable, the enrollee’s rights to have benefits continue pending the resolution of the appeal, and the circumstances under which the enrollee may be required to pay the costs of these services.

Internal or Initial Appeals for Medicaid service denials will be made to the ICO. If the ICO’s decision is sustained in the Initial Appeal, the enrollee may appeal to MOAHR as long as it is within 120 days of the notice of denial of medical coverage. All Appeals must be resolved by the ICO as expeditiously as the enrollee’s condition requires, but always within 30 calendar days of the request for standard appeals, and within 72 hours of the request for expedited appeals. This timeframe may be extended up to 14 days if the party or parties can show there is a need for the delay and it is in the enrollee’s best interest. MOAHR will resolve appeals as expeditiously as the enrollee’s condition requires, but always within 90 calendar days of the received request.

The ICO must continue to provide benefits for all prior approved benefits (excluding Medicare Part D) that are terminated or changed pending ICO Internal Appeals. For all appeals filed with MOAHR, ICOs must continue to cover benefits for requests received within 10 calendar days of the notice of denial of medical coverage. In circumstances where the time for a standard appeal is too long and may seriously jeopardize the enrollee’s life, health, or ability to attain, maintain, or regain maximum function, the ICO or the enrollee’s provider may request an Expedited Appeal. If the Expedited Appeal is denied, the appeal request is moved to the standard appeal timeframe and attempts must be made to notify the enrollee immediately and also provide the enrollee with written notice of the denial within two calendar days.

All appeal decisions must be in writing and must include, but not be limited to, the decision that was reached and the date of the decision. If the appeal decision is not entirely in favor of the enrollee, the following information must be included in the notification to the enrollee: 1) the right to request a State Fair Hearing and how to do so within the 120 calendar days timeframe, 2) the right to receive benefits if the Internal Appeal was received within 10 calendar days of the notice of denial of medical coverage, and 3) the right to request external review through PRIRA and DIFS and how to do so.

Payments for services covered during a pending appeal will not be recouped based on the outcome of the appeal.

Additionally, the Enrollee Handbook (or Member Handbook, the alternative name) which is provided to enrollees upon enrollment will also describe the entire appeals process including the State Fair Hearing process and who to contact if the enrollee has questions or wants to file other complaints.

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).

The types of critical incidents that MDHHS requires to be reported for review and follow-up action are:

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

Illegal activity in the home with potential to cause a serious or major negative event – Any illegal activity in the home that puts the enrollee or the providers coming into the home at risk.

Neglect - 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 or rules, policies, guidelines, written directives, procedures, or Individual Integrated Care and Supports Plans that cause or contribute to non-serious physical harm or emotional harm, death, or sexual abuse of, serious physical harm to an enrollee, or the intentional, knowing or reckless acts of omission or deprivation of essential needs (including medication management).

Physical abuse - The use of unreasonable force on an enrollee with or without apparent harm.

Use of Restraints, seclusions, or restrictive interventions. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

Provider no shows - Instances when a provider is scheduled to be at an enrollee’s home but does not come and back-up service plan is either not put into effect or fails to get an individual to the enrollee’s home in a timely manner. This becomes a critical incident when the enrollee is bed bound or in critical need and is dependent on others.

Sexual abuse - (i) Criminal sexual conduct as defined by sections 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and an enrollee.
(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 an enrollee.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and an enrollee for whom the employee, volunteer, or agent provides direct services.

"Sexual contact" means the intentional touching of the enrollee's or employee's intimate parts or the touching of the clothing covering the immediate area of the enrollee's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, 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.

Theft - A person intentionally and fraudulently takes personal property of another without permission or consent and with the intent to convert it to the taker's use (including potential sale).

Verbal abuse - Intimidation or cruel punishment that causes or is likely to cause mental anguish or emotional harm.

Worker consuming drugs or alcohol on the job – Use of any drugs or alcohol that would affect the abilities of the worker to do his or her job.

Suspicious or Unexpected Death - That which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age. These incidents are often also reported to law enforcement.

Medication errors - Wrong medication, wrong dosage, double dosage, or missed dosage which resulted in death or loss of limb or function or the risk thereof.

ICOs have first line responsibility for identifying, investigating, evaluating and follow-up of critical incidents that occur

with enrollees as listed above. ICOs maintain policies and procedures defining appropriate actions to take upon suspicion or determination of abuse, neglect and exploitation. ICOs establish local reporting procedures, based on MDHHS requirements, for all complaints and critical incidents that jeopardize or potentially jeopardize the health and welfare of enrollees conveyed and detected by ICOs, provider agencies, individual workers, independent supports brokers and enrollees and their allies. MDHHS reviews and approves these reporting procedures.

Michigan Public Act 519 of 1982 (as amended) and MCL 400.11a(1) mandate that all human service providers and health care professionals make referrals to the Department of Human Services Adult Protective Services (DHS-APS) unit as soon as possible when the professional suspects or believes an adult is being abused, neglected, or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. ICOs also must report suspected financial abuse per the Financial Abuse Act (MCL 750.174a). Policies and procedures that ICOs develop must include procedures for follow up activities with DHS-APS to determine the result of the reported incident and next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect or exploitation, as well as the referral to DHS-APS, must be maintained in the participant's case record.

Timeframes are as follows:

ICOs should begin to investigate and evaluate critical incidents with the enrollee within two business days of identification that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.

ICOs are responsible for tracking and responding to individual critical incidents using the Critical Incident Reporting system. When multiple incident types occur on the same day for the same beneficiary separate incident reports must be entered into the Critical Incident Reporting System. ICOs are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of incident. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the ICOs.

For enrollees who are also receiving supports and services through the PIHP for behavioral health, intellectual/developmental disability, or substance use needs, ICOs are required to obtain critical incident reporting information on a monthly basis for critical incidents reported by the PIHP via the critical incident reporting system that exists between PIHPs and MDHHS. ICOs are required to ensure the incidents have been investigated as appropriate.

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.

The State will train ICOs, and ICOs will train participants and their families or legal representatives on how to identify and report suspected abuse, neglect and exploitation, including where to report incidents, e.g., ICOs, DHS-APS, and local law enforcement agencies. The training takes place during face to face interviews with enrollees either during person-centered planning meetings, assessment visits or follow-up meetings. The training is supported by information provided to each enrollee upon waiver enrollment, and when requested or otherwise indicated thereafter. This training is conducted by care coordinators initially during enrollment and initial person-centered planning or assessment, and annually thereafter. Training is provided more frequently when there is indication that it may be needed. Enrollees are also informed that care coordinators are mandated to report suspected incidents of abuse to the DHS-APS and to MDHHS through incident management reports.

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.

ICOs manage critical incidents at the local level. ICOs are responsible to receive reports of critical incidents and ensure the immediate health and welfare of the enrollee. The ICO must also report to the following entities:

Exploitation - Required to report to APS, MDHHS

Neglect - Required to report to APS, MDHHS

Verbal abuse - Required to report to APS, MDHHS

Physical abuse - Required to report to APS, MDHHS

Use of Restraints, seclusions or restrictive interventions: APS, MDHHS

Sexual abuse - Required to report to APS, MDHHS

Theft - MDHHS

Provider no shows, particularly when enrollee is bed bound all day or there is a critical need - MDHHS

Illegal activity in the home with potential to cause a serious or major negative event - local authorities/police, MDHHS

Worker consuming drugs/alcohol on the job - MDHHS

Suspicious or Unexpected Death - Death should be reported to law enforcement if it is a suspicious death possibly linked to abuse or neglect. These types of incidents must also be reported to MDHHS within two business days of the ICO receiving the notice.

Medication errors - MDHHS

ICOs begin to investigate and evaluate critical incidents with the enrollee within two business days of identification that an incident occurred. ICOs are expected to investigate a critical incident until the enrollee is no longer in danger. This may include a removal of the service provider effective the date of the incident or it may involve securing an alternate guardian for the enrollee, which may take several weeks or months. For this reason, MDHHS does not require cases be resolved within a specific timeframe. Cases are only resolved when the enrollee's health and welfare is assured to the extent possible given the enrollee's informed choice for assuming risks. However, MDHHS expects to see an attempt at a resolution within 60 days from the date the incident is reported. If the ICO does not appear to be resolving the issue in a timely manner, MDHHS will contact the ICO to get additional information and provide assistance in resolving the critical incident when possible.

Each ICO is required to maintain written policy and procedures defining appropriate action to take upon suspicion of abuse, neglect or exploitation. This includes identifying and evaluating each incident, initiating prevention strategies and interventions approved by enrollees to reduce or ameliorate further incidents, and follow-up, track, and compile mandatory critical incident reports. The policies and procedures must include procedures for follow-up activities with DHS-APS and law enforcement to determine the result of the reported incident and the next steps to be taken if the results are unsatisfactory. To the extent possible given confidentiality and security concerns covered under Michgan law, the ICO must notify MDHHS via the critical incident reporting system whether the incident was reported to DHS-APS.

The enrollee and any chosen family or allies are updated on the investigation as it progresses. ICOs communicate with the enrollee and family or allies at a minimum of monthly via telephone, but more often as updates or actions occur with the critical incident. Remediation of a critical incident often includes changing services or providers. Care coordinators use a person-centered planning approach with enrollees when suggesting and selecting various options to ensure the health and welfare of enrollees.

MDHHS evaluates and trends the incident reports submitted by the ICOs. Analysis of the strategies employed by the ICOs in an attempt to reduce or ameliorate incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. Training is provided to the ICOs as necessary to educate staff on abuse and to strengthen preventive interventions and strategies.

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.

MDHHS is the state agency responsible for oversight of reporting and response to critical incidents.

ICOs are required to input critical incidents into the online critical incident reporting system. All critical incident reports must include location of incident, provider involved (if applicable), reporting person, information about the enrollee, a description of each incident, action steps, strategies implemented to reduce and prevent future incidents from recurring and follow-up activities conducted through the resolution of each incident. ICOs must initially enter incidents in the system within 30 days of the date of the incident. MDHHS strongly encourages ICOs to report the incident much sooner than 30 days if they are aware of it. MDHHS has access to the critical incident reporting system where they can review reports and follow-up with questions or address concerns with the ICOs, including questions on missing information or completeness of the report.

It is required that ICOs report suspicious or unexpected deaths to MDHHS within two business days. They can notify MDHHS via phone, email or the critical incident reporting system and must follow-up with the formal report due within 30 days of the date of incident.

MDHHS monitors and reviews report submissions. MDHHS reviews, evaluates, and trends individual and summary incident reports submitted by the ICOs at a minimum of every quarter. MDHHS reviews reports that involve providers and alert ICOs if a trend is discovered so new providers can be secured, if necessary. Analysis of the strategies employed by ICOs in an attempt to reduce or prevent incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. MDHHS verifies that ICOs use appropriate related planned services and supportive interventions to prevent future incidents. Training is provided to ICOs as necessary to educate staff on abuse and to strengthen preventive interventions and strategies. MDHHS also verifies that ICOs report incidents of abuse, neglect and exploitation to the Michigan Department of Health and Human Services Adult Protective Services (MDHHS-APS) as required.

Aggregate reports are created and shared with ICOs and with the MI Health Link Advisory Committee and any quality subcommittee that may develop to assist in identifying trends or issues that need to be addressed system-wide to prevent or reduce future occurrences.

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 has qualified reviewers to conduct annuals site reviews and home visits/enrollee interviews . MDHHS reviews a representative sample of case records during the quality record and site reviews. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the ICO submitted a report. If there was not a report, MDHHS would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from occurring again.

Care coordinators also discuss the waiver program and services with enrollees during monthly contacts. Any concerns or issues communicated at that time are thoroughly vetted and instances of restraint usage are discussed.

○ **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:

MDHHS prohibits providers from using restrictive interventions as part of the provision of MI Health Link HCBS waiver services. Lap belts used to keep a person secure in their wheelchair can only be used if an enrollee requests this item through the person-centered planning process and it is clearly documented in the enrollee's Individual Integrated Care and Supports Plan.

MDHHS has qualified reviewers conduct annual site reviews and home visits/enrollee interviews. Part of this process is a discovery process to examine the use of restrictive interventions by family and informal caregivers. MDHHS reviews a representative sample of case records during the quality assurance review. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the ICO submitted a report. If there was not a report, MDHHS would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from happening again. MDHHS would look for information in the critical incident that addresses ways to prevent this restrictive action from occurring again.

The ICO Care Coordinator or LTSS Supports Coordinator also discusses the waiver program and services with enrollees during their monthly contact. Any displeasure communicated at that time is thoroughly vetted and instances of restrictive interventions are investigated.

○ **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.

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:

Appendix G: Participant Safeguards

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

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

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

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

MDHHS prohibits providers from using seclusion as part of the provision of waiver services.

MDHHS has qualified reviewers conduct annual site reviews and home visits. Part of this process is a discovery process to examine the use of seclusion by family and informal caregivers. MDHHS reviews a representative sample of case records during the quality assurance review. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the ICO submitted a report. If there was not a report, MDHHS would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from happening again. MDHHS would look for information in the critical incident that addresses ways to prevent seclusion from occurring in the future.

The ICO Care Coordinator or LTSS Supports Coordinator also discusses the waiver program and services with enrollees during their monthly contact. Any displeasure communicated at that time is thoroughly vetted and instances of seclusion are investigated.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

Most enrollees live in their own homes, in which case the ICOs have ongoing responsibility for second line management and monitoring of enrollee medication regimens (first line management and monitoring is the responsibility of the prescribing medical professional). As part of the assessment and reassessment, ICO Care Coordinators or LTSS Supports Coordinators collect complete information about the enrollee's medications, including what each medication is for, the frequency and dosage. An ICO Care Coordinator or LTSS Supports Coordinator reviews the medication list for potential errors such as duplication, inappropriate dosing, or drug interactions. The ICO Care Coordinator or LTSS Supports Coordinator is also responsible for contacting the physician(s) when there are questions or concerns regarding the enrollee's medication regimen. Regular monitoring of the enrollees is performed by the ICO Care Coordinator or LTSS Supports Coordinator, and includes general monitoring of the effectiveness of the enrollee's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with enrollees, and discussion with direct care and other staff as appropriate.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the ICO must follow-up to address the enrollee's health and welfare as applicable, submit a report via the critical incident reporting system and conduct an investigation. The same is true if a medication error results in the death of an enrollee with the additional requirement that the ICO contact the local authorities for a legal investigation.

Michigan's Department of Licensing and Regulatory Affairs (LARA) licenses and certifies Adult Foster Care and Homes for the Aged. Many MI Health Link HCBS enrollees reside in these types of settings. 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. Enrollees in these licensed settings also benefit from additional review of medications by the ICO Care Coordinator or LTSS Supports Coordinator during assessment and reassessments.

The Michigan Administrative Rule 330.7158 addresses medication administration:
(1) A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
(2) A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
(3) A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
(4) A provider shall review the administration of a psychotropic medication periodically as set forth in the enrollee's Individual Integrated Care and Supports Plan and based upon the enrollee's clinical status.
(5) If an enrollee cannot administer his or her own medication, a provider shall ensure that medication is administered by, or under the supervision of, personnel who are qualified and trained.
(6) A provider shall record the administration of all medication in the enrollee's clinical record.
(7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the enrollee's clinical record.

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

The state requires ICOs to report on medication errors that required medical follow-up or hospitalization as a critical incident in the Critical Incident Reporting system. The ICOs must report these incidents within 30 days and MDHHS reviews those reports. MDHHS also reviews aggregate reports to determine any trends or issues that need to be addressed.

MDHHS is responsible for follow-up and oversight of proper medication management practices. MDHHS contracts with qualified reviewers that conduct an annual quality assurance review process to meet CMS requirements for the review of Individual Integrated Care and Supports Plan authorizations and case record reviews. As part of the review, qualified reviewers examine assessment data including the medication list. If any potentially harmful practices are found that were not addressed by ICO care coordinators or LTSS supports coordinators, qualified reviewers will report this and a corrective action plan will be required. MDHHS may require ICOs to receive additional technical assistance or training as a result of the quality assurance review and critical incident data.

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).

Administration of medications by providers is subject to the provisions set forth in the service definitions and provider qualifications in Appendix C. All providers administering medications to MI Health Link HCBS enrollees are subject to the provisions and limitations established by any licensing parameters established by the State of Michigan. Residential providers are similarly bound to the rules and regulations established by their licensing requirements.

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:

Michigan Department of Health and Human Services

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

Medication errors that required medical follow-up or hospitalization. "Medication errors" means wrong medication, wrong dosage, double dosage or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist enrollees with medications complete an incident report if a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which enrollees have refused medication. Critical incident reporting requirements require a report when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

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

Medication errors that required medical follow-up or hospitalization. "Medication errors" means wrong medication, wrong dosage, double dosage or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist enrollees with medications complete an incident report if a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which enrollees have refused medication. Critical incident reporting requirements require a report when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

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

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

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

The state requires ICOs to report on medication errors that required medical follow-up or hospitalization as a critical incident in the Critical Incident Reporting system. The ICOs must report these incidents within 30 days for MDHHS review. MDHHS is responsible for oversight. MDHHS reviews aggregate reports to determine any trends or issues that need to be addressed.

MDHHS has qualified reviewers conduct an annual quality assurance review process to meet CMS requirements for the review of Individual Integrated Care and Supports Plan authorizations and case record reviews. As part of the review, qualified reviewers examine assessment data including the medication list. If any potentially harmful practices are found that were not addressed by ICO care coordinators or LTSS supports coordinators, qualified reviewers will report this and a corrective action plan will be required. MDHHS may require ICOs or service providers to receive additional technical assistance or training as a result of the quality assurance review process and critical incident data.

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 critical incidents due to suspicious or unexpected death reported within 2 business days of notification that the incident occurred. Numerator: Number of critical incidents due to suspicious or unexpected death reported within 2 business days of notification that the incident occurred. Denominator: Total number of incidents due to suspicious or unexpected death.

Data Source (Select one):
Other
If 'Other' is selected, specify:
record reviews on-site or off-site; online database; critical events and incident reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: ICOs	☒ **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 all critical incidents EXCEPT suspicious/unexplained death reported within 30 days of notification that the incident occurred. Numerator: Number of all critical incidents EXCEPT suspicious/unexplained death reported within 30 days. Denominator: Total number of all critical incidents EXCEPT suspicious/unexplained death.

Data Source (Select one):
Other
If 'Other' is selected, specify:
record reviews on-site and off-site; online database; critical events and incident reports

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

collection/generation *(check each that applies):*	*(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: ICOs	☒ **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&percent of files that show enrollee/family/legal guardians(as appropriate) received info & education on how to report abuse, neglect, exploitation & other critical incidents w/in 60 days of waiver enrollment. Numerator: Number of files that show enrollee/family/legal guardians (as appropriate) received the ANE/CI info & education w/in 60 days. Denominator: Number of enrollee files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Home visits; record reviews on or off-site reports to MDHHS; other documents submitted to MDHHS; other reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Proportionate Random Sample 95% Confidence Level with +/- 5% margin of error
☒ **Other** Specify: ICOs	☒ **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.

Performance Measure:
Number and percent of critical incidents requiring review/investigation where the ICO adhered to the follow-up methods as specified in the approved waiver. Numerator: Number of critical incidents requiring review/investigation where the ICO adhered to follow-up methods. Deonminator: Number of all critical incidents requiring review/investigation reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
record reviews on-site and off-site; online database; critical events and incident reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: ICOs	☒ **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 that were resolved within 60 days.
Numerator: Number of critical incidents reported that were resolved within 60 days.
Denominator: Number of all critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
record reviews on-site and off-site; online database; critical events and incident reports

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The 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 & percent of unauthorized use of restraints/restrictive interventions/seclusions reported as a critical incident. Numerator: Number of unauthorized use of restraints/restrictive interventions/seclusions reported as a critical incident.Denominator: Number of unauthorized use of restraints/restrictive interventions/seclusions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical event or incident reports or record reviews, on-site or off-site; online database; home visits;

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: ICOs	☒ **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 & percent of incidents requiring medical follow-up/hospitalization due to a medication error reported appropriately. Numerator: Number of incidents requiring medical follow-up/hospitalization due to medication error that were reported appropriately.Denominator: Number of incidents requiring medical follow-up/hospitalization due to medication error.

Data Source (Select one):
Other

If 'Other' is selected, specify:
record reviews on-site or off-site; online database; home visits; critical events and incident reports

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

Data Aggregation and Analysis:

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

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

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.

ICOs continuously monitor the health and welfare of enrollees and initiate remedial actions when appropriate. The state identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation on an ongoing basis.

Additional Strategies

1) ICOs conduct risk management planning with enrollees during person-centered planning. Risk management planning includes strategies and methods for addressing health and welfare issues. ICO Care Coordinators or LTSS Supports Coordinators negotiate risk management with the enrollee through the person-centered planning process. ICO Care Coordinators (or LTSS Supports Coordinators) and enrollees monitor and evaluate the effectiveness of risk management plans, i.e., which strategies work and which do not work effectively with that given enrollee. Risk management planning and updates occur at reassessment (quarterly or semi-annually) or more frequently as needed. Risk management is documented in the IICSP.
2) MDHHS verifies that risk management planning is occurring during the quality assurance review process conducted annually. MDHHS includes findings in written monitoring reports, with corrective actions and training as needed.

3) ICOs train enrollees, workers, staff, and supports brokers on how to report abuse, neglect, and exploitation. Technical assistance and training records include attendance by date and total number of attendees, topic and content, and training evaluations.
4) The ICO must submit a critical incident report within 30 days. The critical incident report must include all information about how the incident was investigated and how it is being followed up on. The ICO must update MDHHS as the investigation continues. The corrective action plan must also describe how the ICO will prevent the lack of reporting from happening again. MDHHS reviews critical incident reports that the ICOs enter into the Critical Incident Reporting System at least every quarter to ensure incidents are reported within required timeframes and monitors the type of incident.

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.

The ICO must submit a critical incident report within required timeframes. The critical incident report must include all information about how the incident was investigated and how it is being followed up on. The ICO must update MDHHS as the investigation continues. The corrective action plan must also describe how the ICO will prevent the lack of reporting from happening again.
MDHHS reviews critical incident reports at a minimum of once every quarter. During this review, MDHHS reviews the data to ensure investigations were started and reports were submitted within the required timeframes. If during the review any critical incidents were discovered to not be investigated within required timeframes, the ICO must begin investigation within two business days of the finding. If an investigation had already been started but not in a timely manner, the ICO must include information in their corrective action plan that will explain how they will ensure future critical incidents are investigated timely. The ICO must also follow-up with MDHHS as the investigation of the specific incident is conducted. Corrective action plans must also include plans of how to prevent untimely reporting and investigating of critical incidents.
During the quality assurance review process, reviewers conduct home visits/enrollee interviews with a sample of enrollees from each ICO. If during those home visits/enrollee interviews, any enrollees or legal guardians report not receiving information and education on how to report abuse, neglect, exploitation and other critical incidents, information and education must be provided to those enrollees or guardians within two weeks, and documentation proving this information has been provided must be submitted to MDHHS and kept in the enrollee record.
MDHHS reviews a representative sample of case records during the quality assurance review. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the ICO submitted a report. If there was not a report, MDHHS would consider this a non-evident finding that would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent future occurrences of the critical incident and development of methods to assure timely reporting in the future.
After completing the quality assurance reviews, MDHHS conducts exit conference with the ICO staff. During the exit conference, the ICO is provided with a summary report of findings including any findings that require immediate remediation. The immediate remediation is due within 72 hours. MDHHS also compiles quality assurance review findings from annual audits, critical incident reviews and provider monitoring reviews into draft reports that are sent to the ICO. The ICO will receive a rebuttal period of 5 business days in which they can submit documentation not previously reviewed to support reconsideration of findings. MDHHS will make any revisions to the draft reports as appropriate and the ICO will receive a final report. When the final report indicates a need for corrective action, the ICO has 30 calendar days to respond with a corrective action plan (CAP) utilizing MDHHS template.
Corrective action plans should demonstrate that the ICO has:
1.Analyzed all non-evident findings and determined possible causes;
2.Developed a remediation strategy, including timelines, that address and resolve the problems; and
3.Planned ongoing monitoring of remediation activities and performance.
MDHHS will review the CAP and will accept or request a resubmission. If accepted, the plan will have 90 calendar days to implement. If a resubmission is requested, the plan will be required to update the CAP and resubmit within 7 calendar days. After second submission, if the CAP is not accepted, MDHHS will execute sanctions in accordance with the Three Way Contract until a submitted CAP is accepted. MDHHS may request an independent validation audit in accordance with MDHHS and CMS requirements.
MDHHS will monitor the implementation of the CAP. ICOs are required to provide evidence of their remediation strategy by submitting documentation to MDHHS following the implementation phase utilizing MDHHS template. This documentation might include training materials, revised policies and procedures, information from staff meetings or case record documentation to support the corrective action plan has been implemented. Ongoing monitoring will occur as needed.

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**

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

MDHHS has developed a Quality Strategy for the entire MI Health Link §1915(b)/(c) waiver program. The MI Health Link Quality Strategy monitors ICO performance on many quality indicators as required by CMS and in compliance with 42 CFR 438 Managed Care rules. The quality assurance areas covered under this Quality Strategy are related to Access Standards, Adequacy of Capacity and Services, Coordination and Continuity of Care, and Structure and Operations Standards. The Quality Strategy includes performance measures from Healthcare Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data, Health Outcomes Survey, enrollment and disenrollment reports, External Quality Review reports, quality withhold performance indicators, reports of enrollee complaints, network adequacy, and other ratings and measures, and direct stakeholder input.

MDHHS also oversees performance of ICOs through the MI Health Link HCBS Quality Improvement Strategy. ICOs will be evaluated on their performance related to several performance measures including ensuring appropriate enrollment in the waiver; appropriate level of care determinations were made prior to enrollment in the waiver and ongoing; review and periodic updates of Individual Integrated Care and Supports Plans (IICSP); ensuring residential and non-residential settings are compliant with the HCBS Final Rule issued by CMS on January 14, 2014; ensuring that providers meet specified provider qualifications; ensuring the individual has a choice of services and providers; health and safety of the enrollee; monitoring and reporting of critical incidents, restraints, seclusions, or restrictive interventions; monitoring and reporting of suspicious deaths or injury due to medication error; ensuring training has occurred for reporting critical incidents; ensuring that critical incidents were reported within specific timeframes; ensuring capitation payments were made appropriately for enrollees with Waiver PET Codes; and encounters are submitted timely and accurately. The Quality Improvement Strategy includes on-site/off-site clinical and administrative reviews at ICO or other provider locations, visits to homes of enrollees/enrollee telephonic interviews, off-site record reviews where ICOs send MDHHS requested information, reviewing information in online databases or the MDHHS Data Warehouse, and enrollee surveys. If MDHHS finds the ICOs to be out of compliance with waiver requirements, ICOs must submit to MDHHS corrective action plans and remediate the issue within timeframes required by MDHHS. MDHHS monitors the status and outcome of the corrective action plans.

In addition to the Quality Strategy and the Quality Improvement Strategy, there are opportunities for stakeholders to provide indirect and direct input about various aspects of the MI Health Link program. MDHHS formed an Advisory Committee for the MI Health Link program, providing a mechanism for enrollees and stakeholders to provide input. Individuals and organizations submit applications to MDHHS, and MDHHS then selects members for the Committee. Membership represents the diverse interests of stakeholders from various populations within the four MI Health Link regions. The roles and responsibilities for the Advisory Committee are to:

- solicit input from stakeholders and other consumer groups
- review ICO and PIHP quality data and make recommendations for improvements in services
- provide feedback in the development of public education/outreach efforts and evaluation processes
- identify areas of risks and potential consequences
- participate in Open Forum sessions

Another opportunity for stakeholder involvement is the ICO Advisory Council. Each ICO is required to have an Advisory Council specific to the MI Health Link program. Membership on the Advisory Council is one-third enrollees, with the majority comprised of enrollees, family members, and advocates.

MDHHS designed and implemented a remediation plan following the CMS quality review of the program. The state identified action steps to implement systemic changes and improvements in order to achieve compliance with all assurances. MDHHS has provided quarterly updates to CMS and expects the Remediation Plan to be fully implemented by March 1, 2020.

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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: ICOs	☐ **Other** Specify:

b. System Design Changes

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

MDHHS uses various performance measures to monitor the performance of the ICO on a number of domains: access and availability; care coordination and transitions of care; enrollee and caregiver experience; organizational structure, administration, and staffing; person-centered planning; quality of care, health, and well-being; quality of life; screening, assessment, and prevention; and utilization . Data collected for these performance measures will be reviewed by MDHHS as a means to determine if there are systemic issues that need to be addressed quickly, to identify trends to monitor or opportunities for improvement, to monitor contract compliance, to provide information to the public as necessary.

Critical incidents are reported, reviewed, investigated and acted upon by the each ICO for all MI Health Link HCBS enrollees. MDHHS also monitors critical incident reporting to ensure complaints are being addressed appropriately and timely. MDHHS also monitors critical incident reporting to identify trends or areas in need of training, opportunities for systemic improvement, or systemic issues that need to be addressed quickly to protect the health and welfare of enrollees.

MDHHS monitors adequacy of ICO provider networks to ensure the ICO continues to meet established requirements for provider networks as indicated in the Three-Way Contract. If ICOs do not meet requirements, MDHHS will work with them to come into compliance or terminate the contract if necessary.

The Quality Improvement Strategy for the MI Health Link HCBS waiver includes a number of performance measures to monitor ICO performance in areas such as waiver administration, level of care, provider qualifications, service plan development, health and welfare, and financial accountability. If MDHHS finds ICOs to be out of compliance in these areas as indicated in the waiver application, the ICOs will be required to provide MDHHS with a corrective action plan that explains what the ICO will do to correct the problem and come into compliance. MDHHS will monitor the implementation of the corrective action plan to ensure the plan is being addressed satisfactorily and timely.

MDHHS compiles data from ICOs and other sources and disseminates the information to the Advisory Committee, ICOs, and other stakeholders. The Advisory Committee is specific to MI Health Link and is comprised of a diverse group of enrollees, advocates, and other stakeholders. The committee is designed to solicit input from enrollees, stakeholders, and other consumer groups. The committee will be responsible for many tasks: 1) review ICO and PIHP quality data and make recommendations for improvements in services, 2) provide feedback in the development of public education/outreach campaigns and evaluation, 3) identify areas of risks and potential consequences, and 4) other tasks determined necessary by the group. MDHHS will also be involved in this committee to listen to feedback and determine any system issues that may exist and need to be addressed.

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

MDHHS will evaluate the MI Health Link HCBS Quality Improvement Strategy on an ongoing basis to determine if there are any deficiencies. If deficiencies exist, MDHHS will provide training (presentations, teleconferences, webinars) to ICOs to help bring them into compliance with CMS and MDHHS requirements. MDHHS updates service standards, operating standards and other requirements as necessary to ensure the health and welfare of enrollees and maintain compliance with State and federal requirements.

MDHHS also evaluates and analyzes stakeholder input from the Advisory Committee on an ongoing basis to ensure the MI Health Link program meets the needs of enrollees and also works well for the ICOs.

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).*

Through the Contract Management Team and also the Quality Improvement Strategy, CMS and MDHHS monitor, evaluate, and oversee the financial integrity and accountability of ICOs.

The State has a financial audit program to ensure appropriate payment is provided to ICOs, and also to ensure integrity of provider billing. The process includes the following components:

MDHHS uses HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to ICOs. The 834 process generates an enrollment file (834 file) based upon the ICO provider ID number and the enrollee's assignment to the MI Health Link benefit plan. This process uses edits to assure only the ICOs that have a contract with the State are provided the capitation payment for the MI Health Link program. Each ICO has a unique MI-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to an ICO. This process includes verifying the participant's Medicaid eligibility, the nursing facility level of care determination (NFLOCD), and the current Program Enrollment Type (PET) code. Once all ICO enrollees are identified, the 820 process generates a capitation payment (based on the Program Enrollment Type code) for each ICO using the Medicaid Management Information System (MMIS)(Community Health Automated Medicaid Processing System (CHAMPS)). MDHHS utilizes a six (or up to twelve) month retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 file and associated process.

The repayment and recoupment processes are for the correction of payment for beneficiaries who enrolled in or disenrolled from the ICOs, and for those who were approved for or removed from the 1915(c) waiver, after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the MI Health Link program during a given month when the ICO did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for enrollees who were removed from the 1915(c) waiver program or disenrolled from the MI Health Link program, but the ICOs received capitation payments due to data lags in the 834 process.

A second form of monitoring is that all providers of waiver services contracting with an ICO must submit bills to the ICO detailing the date of service, type of service, unit cost, and the number of units provided for each enrollee served. Bills are then matched and verified against the enrollee's approved IICSP by the ICO prior to submitting encounter data to MMIS. The ICOs process payments for all verified encounters by the providers. ICOs also complete billing audits on a sample of records verifying this information through provider monitoring activities for at least 10% of waiver service providers annually.

Providers operating as an ICO are required to maintain all enrollees' records, including assessments, IICSPs, service logs, reassessments, and quality assurance records for a period of not less than 10 years to support an audit. MDHHS, providers, and the ICOs all maintain records for a period of 10 years to allow for full auditing of payments for services.

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 waiver encounters submitted to MDHHS within required timeframes. Numerator: Number of waiver encounters submitted to MDHHS within required timeframes. Denominator: Number of waiver encounters submitted to MDHHS.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
online database

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:* *ICOs*	☐ ***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 waiver encounters submitted to MDHHS with all required data elements. Numerator: Number of waiver encounters submitted to MDHHS with all required data elements. Denominator: Number of all waiver encounters submitted to MDHHS.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
online database

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:* *ICO*	☐ ***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 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 rates that are consistent with the approved rate methodology in the approved waiver application. Numerator: Number of cap rates that are consistent with the approved rate methodology. Denominator: All cap rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
online database

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 capitation payments made to the ICOs only for MI Health Link HCBS waiver enrollees with active eligibility. Numerator: Number of capitation payments made to the ICOs for MI Health Link HCBS waiver enrollees with active eligibility. Denominator: Total number of all MI Health Link HCBS waiver capitation payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
online database

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:* *ICOs*	☐ ***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.*

Financial Monitoring

MDHHS requires ICOs to conduct annual financial monitoring. This methodology is designed to ensure and verify that:
1) Direct service providers comply with minimum service standards and conditions of participation in the Medicaid program;
2) Providers deliver services according to the MI Health Link enrollee's IICSP;
3) Providers maintain an adequate number of trained staff through recruitment, training, and staff supervision and support; and
4) Providers maintain enrollee case record documentation to support encounter data.

ICO staff reviews, evaluates, and compares direct provider records to work orders, IICSPs, service claims, and reimbursements. ICO staff compares payment records to MI Health Link IICSP authorization (work orders) and other ICO service documentation to ensure they match. ICO staff evaluates provider records for date of service, time of service delivery, staff providing the service, and supervision of staff providing services, notes any discrepancies during the review and includes them in written findings. The ICO staff provides written findings of the review and corrective action requirements (as necessary) to the provider within thirty days following completion of the initial review. The ICO submits provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. MDHHS reviews and evaluates these reports for completeness and integrity of the process.

MDHHS also requires the ICOs to conduct enrollee home visits to accurately gauge the effectiveness of service delivery. The ICO reviewer conducts a minimum of two home visits with enrollees per provider reviewed to determine enrollee satisfaction with care coordination and services and to verify that providers deliver services as planned.
Additionally, MDHHS conducts on-site reviews to verify the ICO maintains administrative and financial accountability. MDHHS reviews and evaluates a sample of enrollee claims from the IICSP during a three month period. This process includes reviewing the service record from inception through reported encounter data to verify that records match by date of service, amount, duration, and type of service.

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.*

When the ICO reviews the provider agency, the ICO written review includes citations of both positive findings and areas needing corrective action. It is the ICO's responsibility to monitor a provider's performance in completing the necessary corrective actions. ICOs may suspend new referrals to a provider agency and transfer enrollees to another provider when findings warrant immediate action to protect an enrollee's health and welfare. ICOs make provider billing adjustments on the computerized client tracking system to the Medicaid Management Information System (MMIS) (CHAMPS)using individual encounter adjustment to date of service or through gross adjustment methodology. The ICO deducts over payments made to a provider from the next warrant issued and due the provider from the ICO. The ICO may suspend or terminate a provider who demonstrates a failure to correct deficiencies following subsequent reviews. The ICO may reinstate providers after verifying that the provider has corrected deficiencies and changed procedural practices as required.

Specific remediation steps to be taken for each performance measure in Financial Accountability:

Number and percent of provider bills that are paid for enrollees of the waiver.

If any provider bills are paid for individuals who are not waiver enrollees:
1. ICOs must recover payments made for services rendered for individuals who were not approved for c-waiver enrollment. Provider billing adjustments can be made in MMIS using individual encounter adjustment to date of service or through gross adjustment methodology.
2. MDHHS utilizes MMIS edits to ensure capitation payments are paid for enrollees of this §1915b/c waiver program only and will not generate capitation payments for non-eligible individuals. Number and percent of ICO financial records that verify provider claims are made in accordance with services ordered authorization per IICSP, and ICO payments to providers are made accordingly.

If ICO financial records do not support provider claims and payments:
1. MDHHS requires the ICO to investigate further to determine if services ordered were provided. If so, the ICO will be required to address revising and improving the provider's financial record-keeping.
2. If services ordered were not provided but a provider claim was submitted and paid, the ICO will need to recover payments and may need to assign an alternate provider for all affected enrollees to ensure services are provided as ordered.

See Appendix C Quality Improvement section of this application for further information about the billing audit completed by ICOs during provider monitoring activities and the associated remediation activities.
MDHHS monitors all ICO provider monitoring reports and compiles results for each ICO. If an ICO is non-compliant with the process and their providers are not compliant with requirements MDHHS will indicate the need for an ICO to complete a corrective action plan following the MDHHS CAP process.

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:* *ICOs*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).*

Capitation Rate Development
The methodology for development of the capitation rates are subject to 1915(b) requirements and criteria.

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:*

ICO billings made to the state are made in accordance with the provisions of the 1915(b) waiver and provider billings to the ICO are made according to the terms of the provider's contract with the ICO.

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.)

Appendix I: Financial Accountability

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

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

a) When the individual is eligible for Medicaid waiver payment on the date of service.

The 820 Premium Payment process is designed to assure the capitation payment is only generated for persons enrolled in the Integrated Care – MI Health Link benefit plan. To enroll in the Integrated Care – MI Health Link benefit plan, persons must be deemed eligible for the MI Health Link HCBS waiver and enrolled by the Department of Human Services as evidenced by a waiver PET Code. The 820 payment process also verifies the enrollee has a valid Nursing Facility Level of Care Determination in the system that indicates the person meets nursing facility level of care criteria. These checks are made before the payment to the ICO is generated. MDHHS also employs a recoupment and repayment process with a six (up to twelve) month look back period to make adjustments to capitation payments made as eligibility and enrollment information is updated to correct for any payment errors that may have occurred.

ICOs verify enrollee eligibility for all dates of service billed by the rendering providers prior to paying provider bills for MI Health Link services delivered. If the ICO finds a provider bill for a date of service when the participant was not eligible, the ICO either does not pay this bill, or uses alternate funding sources if possible. The ICO will not submit encounter data for dates of service in which the participant was not eligible. MDHHS requires the ICO to modify encounter data as necessary so that it only reflects encounters for participants eligible for this MI Health Link §1915(c) waiver on the dates of service claimed.

The ICO is responsible for assuring that only services authorized in an enrollee's Individualized Integrated Care and Supports Plan (IICSP) are submitted as encounter data. The ICO utilizes their information system to compare bills submitted by providers for authorized waiver services in each enrollee's IICSP. Only those services contained within the approved service plan are paid. Claims paid by the ICO to the provider are then submitted to MMIS as encounter data. The MMIS will only accept encounter data for dates of service for which the enrollee was eligible for MI Health Link enrollment.

Each ICO periodically monitors service providers. This monitoring includes an audit of the paid services compared to documentation including in-home logs kept by paid providers, timesheets, and other source documents. Additionally, ICOs have systems for enrollees and service providers to notify the ICO Care Coordinator or LTSS Supports Coordinator when services are not delivered as planned. Any services reported as not delivered will not be paid during the remit process. ICOs are responsible for tracking incidences of provider no-shows.

MDHHS requires ICOs and providers of service(s) to maintain all records for a period of not less than ten years.

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:

At the end of each month, MDHHS will run the 834 Enrollment file for each ICO. This file contains an electronic listing of persons who are enrolled in the MI Health Link program with each ICO. MMIS then performs quality checks including: verification of current Medicare and Medicaid eligibility; a valid NFLOCD indicating the enrollee meets nursing facility level of care; a Waiver PET Code; and the enrollee is not participating in any other long term care program. On the 3rd pay cycle of each month, the 820 premium payment will run and will electronically transfer the appropriate per member per month capitation payment for each enrollee based on the appropriate PET code.

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.

This is a concurrent §1915(b)/(c) waiver.

MDHHS will withhold a percentage of the capitation payments to ICOs and will pay this percentage back to the ICOs at the end of the year based on outcomes related to certain quality assurance performance measures identified and agreed upon by CMS and MDHHS as indicated in the three-way contract. The total payments will not exceed the waiver cost projection because the withhold percentage has been accounted for in the approved capitation payment. This information is also included in the MI Health Link 1915(b) waiver application, Section D, Part I, H (Appendix D3)(d).

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:

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:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

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

○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

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

The monthly capitated payment to the managed care entities is not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

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

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

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

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

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***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.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:

☐ ***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:

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:*

Residential service providers are limited to billing under a finite set of Healthcare Common Procedure Coding System (HCPCS) codes for their services. The codes do not include reimbursement for room and board except for the Respite service when provided in settings such as Adult Foster Care, Homes for the Aged, nursing facilities or other State-approved facilities. MDHHS did not include costs associated with room and board in the capitation rate development process. ICOs negotiate rates with each residential service provider based upon the unique needs and circumstances of each enrollee in the residential setting on an individual basis. All MI Health Link HCBS services are based upon the assessed medical and functional needs of the enrollee. All payments to providers in residential settings are for approved MI Health Link HCBS services only. MMIS will only approve encounter data claims for the approved HCPCS codes.

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: Nursing Facility

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	17804.14	4113.06	21917.20	43613.18	3534.83	47148.01	25230.81
2	24574.90	5547.12	30122.02	44590.88	3604.54	48195.42	18073.40
3	25392.71	5723.98	31116.69	45590.49	3675.62	49266.11	18149.42
4	26299.46	5934.92	32234.38	46612.52	3748.10	50360.62	18126.24
5	27266.78	6148.04	33414.82	47657.45	3822.01	51479.46	18064.64

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:
		Nursing Facility
Year 1	4974	4974
Year 2	5077	5077
Year 3	5181	5181
Year 4	5284	5284
Year 5	5388	5388

Appendix J: Cost Neutrality Demonstration

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

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

The average length of stay (ALOS) has been projected based on actual experience from the current waiver period, reflecting year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate of 238 for WY1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count (1,184,308/4974). The ALOS is calculated based on actual experience through July 2019 and estimated phase-in and phase-out assumptions for future time periods. Changes in ALOS over the course of the 5-year renewal period are based on projected changes in enrollees over the waiver period and reflecting slightly shorter stays with more people phasing into the waiver than phasing out in a given year. The ALOS is higher in WY 2-5 based on lower phase-in assumptions over the last 48 months of the renewal period.

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:*

Due to data quality limitations of the MI Health Link encounter experience for the NFLOC waiver population, development of the Factor D costs for the MI Health Link Program is based on an allocation of the managed care capitation rates paid to the ICOs. We applied an allocation the actual CY2018 payments made to the ICOs based on the service distributions reported in J-2-d for the MI Choice Waiver year spanning October 1, 2018 through September 30, 2019. Factor D for the 5 year renewal period was projected from the allocation of the CY2018 capitation payments assuming increases in utilization proportional to the growth in unique participants and a 3% annual unit cost trend. The 3% prospective trend rate is consistent with the prospective trend rate that was utilized in developing the SFY 2020 MI Choice managed care program capitation rates. Because the MI Choice rates are utilized as the basis for the MI Health Link waiver tier capitation rates and cover similar services, we utilized a consistent trend rate for the Factor D costs
The capitation rates paid to MI Choice managed care program waiver agencies in Michigan are utilized as the basis for establishing the 1915(c) waiver cost portion of the capitation rates paid to the MI Health Link ICOs. As the historical encounter data reported by the ICOs does not accurately reflect the costs experienced by the ICOs, we utilized a different source of information for developing the costs included in the 1915(c) submission. We allocated the capitation payments made to the ICOs to the service lines on Appendix J-2-d based on historically reported experience from the MI Choice waiver agencies. The three components of the waiver service utilization and cost were as follows:
•The estimated number of users was developed using the percentage of members within the MI Choice program utilizing a specific waiver service and adjusted the user count to reflect the estimated unduplicated participant counts for the MI Health Link 1915(c) waiver program.
•The average units per user was developed directly from historical information from the MI Choice program.
•The average cost per unit for the MI Health Link 1915(c) waiver was calculated by determining the aggregate expenditures associated with a waiver service and dividing by the number of users and average units per user.
-The aggregate expenditures for a waiver service within the MI Health Link waiver was established by determining the percentage of the total waiver related capitation payments for SFY 2018 paid to the ICOs based on historical distribution of reported MI Choice reported costs.
-This methodology was employed based on the lack of reliability in the utilization and unit cost information reported by the ICOs for waiver services.
The unduplicated participant projections were developed based on actual 1915(c) waiver enrollment and the average phase-in and phase-out patterns we observed in recent historical periods and consideration to the state's strategy to place increased focus on increasing waiver enrollment. We did not apply percentage adjustments to the unduplicated participant counts, but rather maintained a consistent number of phase-in and phase-out assumptions over the 5-year waiver period.

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:*

Factor D' was derived using the MHL non-waiver FFS experience for CY2018. It additionally included a provision for the estimate of Community Transition Services which were removed as a 1915(c) capitated service effective April 2019 and transitioned to a 1915(i) State Plan service. The Factor D' values for the future time periods were developed assuming increases in utilization proportional to the growth in unique participants and a 3% annual unit cost trend. The 3% prospective trend rate is consistent with the prospective trend rate that was utilized in developing the SFY 2020 MI Choice managed care program capitation rates. Because the MI Choice rates are utilized as the basis for the MI Health Link waiver tier capitation rates and cover similar services, we utilized a consistent trend rate for the Factor D costs. The 3% prospective trend rate was selected to be consistent with the prospective trend rate that was applied to the Factor D, or 1915(c) waiver costs.

A consistent prospective trend rate of 3% was applied to the base costs of services within Factor D'. The change in ALOS and unduplicated participants also plays a role in developing the average PMPM which impacts the year-over-year trend in the Factor D' PMPM. Thus, a 3% growth rate was applied to the cost per unit, but other factors vary the PMPM change from year to year.

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 projections estimates are consistent with those derived for MI Choice Waiver Amendment for the period of October 1, 2018 through September 30, 2023, with an additional year of trend to reflect the effective date of the MHL Waiver period.

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' projection estimates are consistent with those derived for MI Choice Waiver Amendment for the period of October 1, 2018 through September 30, 2023, with an additional year of trend to reflect the effective date of the MHL Waiver period.

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	
Adult Day Program	
Respite	
Adaptive Medical Equipment and Supplies	
Fiscal Intermediary	
Assistive Technology	
Chore Services	
Community Transition Services (terminated effective 04/24/2019)	
Environmental Modifications	
Expanded Community Living Supports	
Home Delivered Meals	
Non-Medical Transportation	
Personal Emergency Response System	
Preventive Nursing Services	
Private Duty Nursing	

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
Adult Day Program Total:							**1272793.76**
Adult Day Program	☒	15 minutes	149	2104.00	4.06	**1272793.76**	
Respite Total:							**358424.62**
Respite - Per Diem	☒	Per Diem	47	13.00	200.24	**122346.64**	
Respite	☒	15 minutes	87	694.00	3.91	**236077.98**	
Adaptive Medical Equipment and Supplies Total:							**571698.60**
Adaptive Medical Equipment and Supplies	☒	Item	1455	188.00	2.09	**571698.60**	
Fiscal Intermediary Total:							**688248.00**
Fiscal Intermediary	☒	Month	792	10.00	86.90	**688248.00**	
Assistive Technology Total:							**154843.15**
Assistive Technology	☒	Item	185	7.00	119.57	**154843.15**	
Chore Services Total:							**409960.32**
Chore Services	☒	15 Minutes	376	88.00	12.39	**409960.32**	
Community Transition Services (terminated effective 04/24/2019) Total:							**0.00**
Community Transition Services (terminated effective 04/24/2019)	☒	Transition	0	0.00	0.01	**0.00**	
Environmental Modifications Total:							**264100.46**
Environmental Modifications	☒	Service	109	1.00	2422.94	**264100.46**	
Expanded Community Living Supports Total:							**71610780.36**

GRAND TOTAL:	**88557788.40**
Total: Services included in capitation:	88557788.40
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**4974**
Factor D (Divide total by number of participants):	**17804.14**
Services included in capitation:	17804.14
Services not included in capitation:	
Average Length of Stay on the Waiver:	238

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expanded Community Living Supports	☒	Transition	4711	3363.00	4.52	71610780.36	
Home Delivered Meals Total:							2471826.00
Home Delivered Meals	☒	Meal	1400	257.00	6.87	2471826.00	
Non-Medical Transportation Total:							5985662.76
Non-Medical Transportation	☒	Trip/Mile	1193	924.00	5.43	5985662.76	
Personal Emergency Response System Total:							434654.64
Personal Emergency Response System	☒	Month	1869	8.00	29.07	434654.64	
Preventive Nursing Services Total:							345753.45
Preventive Nursing Services	☒	15 Minutes	545	171.00	3.71	345753.45	
Private Duty Nursing Total:							3989042.28
Private Duty Nursing	☒	15 Minutes	47	7551.00	11.24	3989042.28	

GRAND TOTAL:	88557788.40
Total: Services included in capitation:	88557788.40
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	4974
Factor D (Divide total by number of participants):	17804.14
Services included in capitation:	17804.14
Services not included in capitation:	
Average Length of Stay on the Waiver:	238

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
Adult Day Program Total:							**1786632.32**
Adult Day Program	☒	15 minutes	152	2812.00	4.18	**1786632.32**	
Respite Total:							**510687.09**
Respite - Per Diem	☒	Per Diem	48	18.00	206.25	**178200.00**	
Respite	☒	15 minutes	89	927.00	4.03	**332487.09**	
Adaptive Medical Equipment and Supplies Total:							**801380.25**
Adaptive Medical Equipment and Supplies	☒	Item	1485	251.00	2.15	**801380.25**	
Fiscal Intermediary Total:							**1012537.12**
Fiscal Intermediary	☒	Month	808	14.00	89.51	**1012537.12**	
Assistive Technology Total:							**232772.40**
Assistive Technology	☒	Item	189	10.00	123.16	**232772.40**	
Chore Services Total:							**578181.12**
Chore Services	☒	15 Minutes	384	118.00	12.76	**578181.12**	
Community Transition Services (terminated effective 04/24/2019) Total:							**0.00**
Community Transition Services (terminated effective 04/24/2019)	☒	Transition	0	0.00	0.01	**0.00**	
Environmental Modifications Total:							**554029.86**
Environmental Modifications	☒	Service	111	2.00	2495.63	**554029.86**	
Expanded Community Living Supports Total:							**100687860.42**

GRAND TOTAL:	**124766779.98**
Total: Services included in capitation:	124766779.98
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5077**
Factor D (Divide total by number of participants):	**24574.90**
Services included in capitation:	24574.90
Services not included in capitation:	
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expanded Community Living Supports	☒	15 Minutes	4809	4493.00	4.66	100687860.42	
Home Delivered Meals Total:							3480358.08
Home Delivered Meals	☒	Meal	1429	344.00	7.08	3480358.08	
Non-Medical Transportation Total:							8401837.08
Non-Medical Transportation	☒	Trip/Mile	1218	1234.00	5.59	8401837.08	
Personal Emergency Response System Total:							628380.72
Personal Emergency Response System	☒	Month	1908	11.00	29.94	628380.72	
Preventive Nursing Services Total:							484253.76
Preventive Nursing Services	☒	15 Minutes	556	228.00	3.82	484253.76	
Private Duty Nursing Total:							5607869.76
Private Duty Nursing	☒	15 Minutes	48	10089.00	11.58	5607869.76	

GRAND TOTAL:	124766779.98
Total: Services included in capitation:	124766779.98
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	5077
Factor D (Divide total by number of participants):	24574.90
Services included in capitation:	24574.90
Services not included in capitation:	
Average Length of Stay on the Waiver:	318

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
Adult Day Program Total:							**1883901.00**
Adult Day Program	☒	15 minutes	155	2820.00	4.31	**1883901.00**	
Respite Total:							**538586.58**
Respite - Per Diem	☒	Per Diem	49	18.00	212.44	**187372.08**	
Respite	☒	15 minutes	91	930.00	4.15	**351214.50**	
Adaptive Medical Equipment and Supplies Total:							**843733.80**
Adaptive Medical Equipment and Supplies	☒	Item	1515	252.00	2.21	**843733.80**	
Fiscal Intermediary Total:							**1064910.00**
Fiscal Intermediary	☒	Month	825	14.00	92.20	**1064910.00**	
Assistive Technology Total:							**244820.50**
Assistive Technology	☒	Item	193	10.00	126.85	**244820.50**	
Chore Services Total:							**607803.84**
Chore Services	☒	15 Minutes	392	118.00	13.14	**607803.84**	
Community Transition Services (terminated effective 04/24/2019) Total:							**0.00**
Community Transition Services (terminated effective 04/24/2019)	☒	Transition	0	0.00	0.01	**0.00**	
Environmental Modifications Total:							**580933.00**
Environmental Modifications	☒	Service	113	2.00	2570.50	**580933.00**	
Expanded Community Living Supports Total:							**106177708.80**

GRAND TOTAL:	**131559655.93**
Total: Services included in capitation:	131559655.93
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5181**
Factor D (Divide total by number of participants):	**25392.71**
Services included in capitation:	25392.71
Services not included in capitation:	
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expanded Community Living Supports	☒	15 Minutes	4908	4507.00	4.80	106177708.80	
Home Delivered Meals Total:							3666942.90
Home Delivered Meals	☒	Meal	1458	345.00	7.29	3666942.90	
Non-Medical Transportation Total:							8863683.84
Non-Medical Transportation	☒	Trip/Mile	1243	1238.00	5.76	8863683.84	
Personal Emergency Response System Total:							660500.28
Personal Emergency Response System	☒	Month	1947	11.00	30.84	660500.28	
Preventive Nursing Services Total:							510282.99
Preventive Nursing Services	☒	15 Minutes	567	229.00	3.93	510282.99	
Private Duty Nursing Total:							5915848.40
Private Duty Nursing	☒	15 Minutes	49	10120.00	11.93	5915848.40	

GRAND TOTAL:	131559655.93
Total: Services included in capitation:	131559655.93
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	5181
Factor D (Divide total by number of participants):	25392.71
Services included in capitation:	25392.71
Services not included in capitation:	
Average Length of Stay on the Waiver:	319

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
Adult Day Program Total:							**1990913.76**
Adult Day Program	☒	15 minutes	158	2838.00	4.44	**1990913.76**	
Respite Total:							**568623.96**
Respite - Per Diem	☒	Per Diem	50	18.00	218.81	**196929.00**	
Respite	☒	15 minutes	93	936.00	4.27	**371694.96**	
Adaptive Medical Equipment and Supplies Total:							**894740.40**
Adaptive Medical Equipment and Supplies	☒	Item	1545	254.00	2.28	**894740.40**	
Fiscal Intermediary Total:							**1118176.78**
Fiscal Intermediary	☒	Month	841	14.00	94.97	**1118176.78**	
Assistive Technology Total:							**257400.20**
Assistive Technology	☒	Item	197	10.00	130.66	**257400.20**	
Chore Services Total:							**644028.00**
Chore Services	☒	15 Minutes	400	119.00	13.53	**644028.00**	
Community Transition Services (terminated effective 04/24/2019) Total:							**0.00**
Community Transition Services (terminated effective 04/24/2019)	☒	Transition	0	0.00	0.01	**0.00**	
Environmental Modifications Total:							**608952.60**
Environmental Modifications	☒	Service	115	2.00	2647.62	**608952.60**	
Expanded Community Living Supports Total:							**112148917.40**

GRAND TOTAL:	**138966325.95**
Total: Services included in capitation:	138966325.95
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5284**
Factor D (Divide total by number of participants):	**26299.46**
Services included in capitation:	26299.46
Services not included in capitation:	
Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expanded Community Living Supports	☒	15 Minutes	5006	4535.00	4.94	112148917.40	
Home Delivered Meals Total:							3875077.39
Home Delivered Meals	☒	Meal	1487	347.00	7.51	3875077.39	
Non-Medical Transportation Total:							9368973.04
Non-Medical Transportation	☒	Trip/Mile	1268	1246.00	5.93	9368973.04	
Personal Emergency Response System Total:							694047.42
Personal Emergency Response System	☒	Month	1986	11.00	31.77	694047.42	
Preventive Nursing Services Total:							538407.00
Preventive Nursing Services	☒	15 Minutes	578	230.00	4.05	538407.00	
Private Duty Nursing Total:							6258068.00
Private Duty Nursing	☒	15 Minutes	50	10184.00	12.29	6258068.00	

GRAND TOTAL:	138966325.95
Total: Services included in capitation:	138966325.95
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	5284
Factor D (Divide total by number of participants):	26299.46
Services included in capitation:	26299.46
Services not included in capitation:	
Average Length of Stay on the Waiver:	321

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
Adult Day Program Total:							**2101359.12**
Adult Day Program	☒	15 minutes	161	2856.00	4.57	**2101359.12**	
Respite Total:							**600227.66**
Respite - Per Diem	☒	Per Diem	51	18.00	225.37	**206889.66**	
Respite	☒	15 minutes	95	941.00	4.40	**393338.00**	
Adaptive Medical Equipment and Supplies Total:							**943818.75**
Adaptive Medical Equipment and Supplies	☒	Item	1575	255.00	2.35	**943818.75**	
Fiscal Intermediary Total:							**1175013.84**
Fiscal Intermediary	☒	Month	858	14.00	97.82	**1175013.84**	
Assistive Technology Total:							**270505.80**
Assistive Technology	☒	Item	201	10.00	134.58	**270505.80**	
Chore Services Total:							**682502.40**
Chore Services	☒	15 Minutes	408	120.00	13.94	**682502.40**	
Community Transition Services (terminated effective 04/24/2019) Total:							**0.00**
Community Transition Services (terminated effective 04/24/2019)	☒	Transition	0	0.00	0.01	**0.00**	
Environmental Modifications Total:							**638129.70**
Environmental Modifications	☒	Service	117	2.00	2727.05	**638129.70**	
Expanded Community Living Supports Total:							**118593029.80**

GRAND TOTAL:	**146913423.60**
Total: Services included in capitation:	146913423.60
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**5388**
Factor D (Divide total by number of participants):	**27266.78**
Services included in capitation:	27266.78
Services not included in capitation:	
Average Length of Stay on the Waiver:	323

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expanded Community Living Supports	☒	15 Minutes	5105	4564.00	5.09	118593029.80	
Home Delivered Meals Total:							4095110.16
Home Delivered Meals	☒	Meal	1516	349.00	7.74	4095110.16	
Non-Medical Transportation Total:							9898988.19
Non-Medical Transportation	☒	Trip/Mile	1293	1253.00	6.11	9898988.19	
Personal Emergency Response System Total:							728838.00
Personal Emergency Response System	☒	Month	2025	11.00	32.72	728838.00	
Preventive Nursing Services Total:							569822.16
Preventive Nursing Services	☒	15 Minutes	589	232.00	4.17	569822.16	
Private Duty Nursing Total:							6616078.02
Private Duty Nursing	☒	15 Minutes	51	10247.00	12.66	6616078.02	

GRAND TOTAL:	146913423.60
Total: Services included in capitation:	146913423.60
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	5388
Factor D (Divide total by number of participants):	27266.78
Services included in capitation:	27266.78
Services not included in capitation:	
Average Length of Stay on the Waiver:	323