Minimum Operating Standards

for MI Health Link Program and

MI Health Link HCBS Waiver

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging
Services Administration

Version 12

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Table of Contents

1. Definitions

i. **Activities of Daily Living (ADLs):** personal care services such as eating, grooming, dressing, bathing, toileting, mobility and transferring.
ii. **Instrumental Activities of Daily Living (IADLs):** personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration.
iii. **Individual Integrated Care and Supports Plan (IICSP):** the name of the person-centered plan for the MI Health Link program.
iv. **Three-Way Contract:** The Capitated Financial Alignment Demonstration contract signed by the Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and each Integrated Care Organization (ICO).
v. **Medical Services Administration (MSA):** The former name of the Health and Aging Services Administration (HASA) of the Michigan Department of Health and Human Services.
vi. **Health and Aging Services Administration (HASA):** The former name of the Behavioral and Physical Health and Aging Services Administration (BPHASA).

This document will be updated as needed to reflect any information changes for the MI Health Link program.

As used throughout this document, "ICO" refers to Integrated Care Organizations or the first tier downstream or related entities as per the Three-Way Contract and the contracts between the ICO and the first tier downstream or related entities.

2. Program Enrollment Type (PET) Codes

MDHHS has assigned specific PET codes for the MI Health Link program. Please refer to policy bulletin MSA 17-40 and the April 2018 Medicaid Provider Manual release.

3. MSA-2565-C Form

As a result of the Community Health Automated Medicaid Processing System (CHAMPS) Modernizing Continuum of Care (MCC) project, the MSA-2565-C form will no longer be used for nursing facility admissions. Nursing facilities will submit nursing facility admissions and discharges directly through CHAMPS. Please see policy bulletins MSA 17-33 and 17-46 for more information.

4. Nursing Facility Level of Care Determination (LOCD)

This section includes general LOCD requirements and LOCD requirements specific to nursing facilities/County Medical Care Facilities and HCBS Waiver.

4.1 General LOCD Requirements for All LOCDs

1. ICOs must conduct the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD or LOCD) tool for all MI Health Link enrollees in nursing facilities and those who are applying for the MI Health Link HCBS waiver.
2. ICOs must follow Michigan Medicaid LOCD policy, the Three-Way Contract, the guidance in this Minimum Operating Standards document and other current/most recent guidance provided by MDHHS. (Nursing Facility Level of Care Determination chapter added to Michigan Medicaid Provider Manual 4/1/19 - MedicaidProviderManual.pdf)
3. All LOCDs conducted by ICOs or their vendors MUST be entered in CHAMPS regardless of whether the enrollee meets LOCD. LOCDs, including those under Door 0, must be on record in CHAMPS.
4. The Freedom of Choice form MUST be completed for each LOCD. ICOs should refer to Section 5.1: Freedom of Choice Form of the Nursing Facility Level of Care Determination Chapter of the MDHHS Medicaid Provider Manual for additional instructions on completion of the FOC.
    - Section 1 must be completed and signed by the individual who conducted the LOCD and dated with the date the LOCD was conducted. NO EXCEPTIONS!
    - Section 2 must be signed by the enrollee or legal representative unless that person refuses to sign or is unable to be reached after a minimum of three attempts made on different dates and times.
    - Under Section 2, if the member selects that they want to receive services through another program such as MI Choice or PACE, ICOs must discuss this option further with the member so the member knows that if they want to receive services through these other programs, they must disenroll from MI Health Link. If they need to disenroll from MI Health Link, ICOs should ensure the member has the contact information for Michigan ENROLLS. It must also be communicated that the members may be put on a waiting list for MI Choice. For transitions to MI Choice, ICOs should contact INTEGRATEDCARE@michigan.gov with “MHL/MI Choice Transition” in the email subject line so MI Health Link and MI Choice staff can coordinate a smooth transition.
    - Section 3 of the Freedom of Choice form does not need to be completed by the ICO as the ICO is not making the eligibility determination. MDHHS will be sending appeal rights information.

- When an individual residing in long term care facility is found functionally

ineligible based on the LOCD, the Notice provided by the State will indicate the date in which services are to stop. ICOs will receive a copy of the Notice and must coordinate with the nursing facilities who are responsible for providing a discharge notice when applicable.

- For LOCD notices for HCBS Waiver enrollments, the service end date will be the end of the month following the 10-day period by which an individual must file an appeal. If an enrollee is notified that they no longer meet LOCD less than 10 days before the end of the month, the individual will remain enrolled on the HCBS Waiver for another month to allow for the 10-day appeal period.
  - If the enrollee files an appeal within 10 days of the Adverse Notice, services will continue pending the final appeal decision.

5. The most recent version of the Freedom of Choice form can be found at: Freedom_of_Choice-FORM.pdf
6. An active LOCD must be in CHAMPS in order for the ICO to receive a Tier 1 or Tier 2 capitation payment. If an LOCD is not in CHAMPS by the 1st of the month that payment would otherwise be made, the ICO will not receive the Tier 1 or Tier 2 payment, as applicable, for that month's payment cycle.
   - If the LOCD is entered in CHAMPS after the 1st of the month, but sometime within the month in which payment should be made, CHAMPS should recognize the LOCD for the next month's payment cycle and pay the correct rate Tier for the previous month.
   - For Nursing Facility cases, if there is not a LOCD in CHAMPS at the time of payment, a tier 3 payment will be made to the ICO.
7. If any adjustments need to be made to LOCD start or end dates in CHAMPS due to CHAMPS errors or data entry errors, these adjustments WILL NOT BE MADE if the ICO has not followed LOCD policy, the Three-Way Contract, this Minimum Operating Standards document, and other MDHHS guidance. In the event of a program audit, MDHHS needs to ensure any LOCD changes are in accordance with policy, guidance and contractual requirements.
   - If an ICO is requesting an adjustment to an LOCD record (start date, Provider ID, etc.), the ICO must provide formal documentation as to when the LOCD was actually conducted (via Freedom of Choice form signed by the person conducting the LOCD) and the date of the long term care facility admission if applicable. If the LOCD is for an HCBS Waiver enrollment or ongoing waiver eligibility, the facility admission date is not needed.
8. Pursuant to MSA 18-39 effective November 1, 2018, The LOCD will now be associated with the beneficiary, rather than the facility or service provider in which the beneficiary is admitted or enrolled. Therefore, if a beneficiary is seeking admission or enrollment in a program and has a current LOCD, the ICO

can use that LOCD for functional eligibility. The ICO may also choose to conduct a new LOCD. The ICO is responsible for confirming that a current LOCD is in CHAMPS, monitoring its end-date to avoid an interruption in eligibility, and conducting another LOCD prior to the LOCD end-date. The ICO is also responsible for conducting a new LOCD if there is a significant change in the beneficiary's condition. To use an LOCD conducted by another provider, the ICO must look in CHAMPS to determine if there is a current LOCD for the beneficiary. The ICO is responsible for ensuring ongoing functional eligibility. Therefore, if the ICO questions the accuracy of the existing LOCD, the provider should conduct a new LOCD.

- The Freedom of Choice (FOC) form must be completed each time the beneficiary changes programs or providers, regardless of if there is a new LOCD conducted. Applicants must acknowledge that they have been informed of their program options in writing by signing the FOC form. If the applicant has a legal representative, they must sign the FOC form. The health professional conducting or adopting the LOCD must also sign and date the form. The completed form (i.e., signed and dated) must be kept in the beneficiary's record. If adopting an LOCD, the ICO can use a blank paper FOC form, but the preferred method would be to print the FOC from CHAMPS for the LOCD you are adopting. This way the application ID will be printed on the FOC to match the LOCD. The provider's name and NPI or provider ID of the entity that conducted the LOCD will appear at the top of the form but the healthcare professional signing as adopting the LOCD will note their title and date and can write in the provider ID of the ICO.

9. Verification Review: Effective 3/22/19 A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee. CHAMPS will randomly select a statistically significant sample of LOCDs entered into the system. Upon submission of an LOCD in the system, CHAMPS will immediately notify the provider if the LOCD was selected for review. The provider is required to submit all relevant documentation used to support the LOCD. Documents must be uploaded electronically in CHAMPS within one business day of the LOCD being selected for verification review. Please refer to the MDHHS LOCD webpage (Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)) for a Verification Document Upload Guide for detailed instructions on how to upload supporting documents. The LOCD webpage also provides job aids that includes examples of the types of supporting documentation to upload for both eligible and non-eligible (Door 0) LOCDs (see also Appendix 3). The related CHAMPS LOCD application ID must be indicated on all documents for tracking purposes. MDHHS or its designee will make a determination within 2 business days of receipt of supporting documentation. The LOCD verification status will change depending on their findings.

10. The ICO or beneficiary may request an LOCD Secondary Review when an LOCD is entered into CHAMPS and results in a Door 0 indicating ineligibility. The review is a secondary review of documentation completed by MDHHS or its designee for all LOCD doors. The beneficiary has three business days to make a request for Secondary Review following written notice of the adverse action. See the NFLOCD Chapter of the Provider Manual for further details.
11. When an LOCD is reviewed by MDHHS or its designee through Verification or Secondary review and they do NOT agree with the findings of the provider's LOCD, they will complete a new LOCD. This new LOCD will inactivate the provider submitted LOCD. Providers can monitor the outcome of reviews by reviewing LOCD statuses in CHAMPS.
12. Passive Redetermination: The initial LOCD for a beneficiary must be conducted in an in-person meeting by a qualified and licensed health professional. Under certain conditions, MDHHS will use a passive redetermination process based upon information from the beneficiary's most recent assessment. When this assessment data is available, MDHHS will apply an algorithm that uses the common assessment items to allow CHAMPS to generate a new LOCD for the beneficiary. An LOCD generated by CHAMPS can be adopted by all LTSS programs. The algorithm used for passive redetermination is not able to verify eligibility through all LOCD doors as follows:

    Door 1: Activities of Daily Living Yes
    Door 2: Cognitive Performance Yes
    Door 3: Physician Involvement MDS Yes
    iHC No
    Door 4: Treatments and Conditions No
    Door 5: Skilled Rehabilitation Therapy Yes
    Door 6: Behavior
    MDS Yes
    iHC Partial
    Door 7: Service Dependency No Door 8: Frailty No

    When the passive redetermination process occurs but the process cannot confirm eligibility based on MDS or iHC data, CHAMPS will create a LOCD Door 87 with an end date of 45 days later or the current LOCD end date whichever is sooner.

    When a beneficiary is currently eligible through a door 4, 7, or 8 that the passive redetermination cannot confirm, the LOCD will be bypassed from the passive redetermination process and the current end date will remain.

4.2 Door 0 Process

Effective July 17, 2019, when an ICO enters an LOCD into CHAMPS that results in a Door 0 they must also upload the supporting documentation in CHAMPS. This upload must take place at the time of initial submission of the LOCD. A job aid can be found here https://www.michigan.gov/documents/mdhhs/VR_Document_Upload_Guide_655824_7.pdf The ICO will continue to complete section 1 and 2 of the Freedom of Choice form at time they conduct LOCD.

From July 16-July 31, 2019, all door 0s will be reviewed by MHL staff who will make the eligibility determination. If the MHL reviewer determines the LOCD is a Door 0 they will provide Notice and Hearing Request to the beneficiary and the ICO will be copied. If an Administrative Hearing is requested, both MDHHS and ICO will be notified and expected to participate as witnesses. If the MHL reviewer determines that the beneficiary is eligible based on their review they will contact the ICO to further discuss their findings and next steps.

Effective August 1, 2019, and ongoing the ICO must continue to upload all supporting documentation in CHAMPS at the time of submission of a Door 0 LOCD. MDHHS's contractor, MPRO, will review every door 0 and make the determination of eligibility. MPRO will enter a new LOCD after each review whether they find the beneficiary to be eligible or ineligible. If MPRO determines the beneficiary is ineligible based on the information submitted, they will enter a new Door 0 into CHAMPS which will inactivate the ICO entered Door 0. MPRO will provide Notice and Hearing Request to the beneficiary, and the ICO and MDHHS will be copied. All 3 parties would be notified and required to participate in any Administrative Hearing as witnesses. If MPRO determines that the beneficiary is eligible based on the information submitted, MPRO will complete and enter a new LOCD into CHAMPS which will inactivate the ICO Door 0 LOCD. MPRO will send a letter to the ICO and copy MDHHS indicating that the beneficiary was found eligible. These letters are mailed. ICO will be able to check the status of any Door 0 they have submitted in CHAMPS (keeping in mind the 2-business day turnaround time.) The ICO must adopt the eligible LOCD by conducting the FOC form with the beneficiary. ICOs should refer to Section 5.1: Freedom of Choice Form of the Nursing Facility Level of Care Determination Chapter of the MDHHS Medicaid Provider Manual for additional instructions on completion of the FOC.

The beneficiary may request a Secondary Review. If a Secondary review is requested when MPRO was the initial reviewer, a different MPRO reviewer will complete the second review of the LOCD than completed the first review. ICO

Door 0s may also still be selected through the system for Verification Review. (This is because system changes have not been made related to this change in process.)

The LOCD review timeframe (whether by MDHHS or MPRO) will be the same as is currently in policy for Verification Review (two business days).

4.3 Nursing Facility LOCDs (not HCBS Waiver)

1. LOCD must be conducted and entered in CHAMPS by the first day of the Nursing Facility stay. ICOs may adopt a current LOCD, or delegate completion of the LOCD to the Nursing Facility. If an ICO delegates completion of the LOCD to the Nursing Facility, the ICO may obtain a copy of the Freedom of Choice form from the Nursing Facility for their records. However, if the enrollee changes programs (e.g. NF to MHL HCBS waiver) the ICO would need to complete a new FOC to adopt the NF LOCD for the new program enrollment. ICOs should refer to Section 5.1: Freedom of Choice Form of the Nursing Facility Level of Care Determination Chapter of the MDHHS Medicaid Provider Manual for additional instructions on completion of the FOC.
2. All LOCDs must be renewed according to 1-year timeframes established in MDHHS guidance.
3. If a long term care facility admission occurs on or after the ICO enrollment effective date, the ICO is responsible for conducting, (or adopting a current LOCD) and the Freedom of Choice form for their members that reside in nursing facilities. If ICO is adopting a current LOCD from another provider, the FOC should be completed and retained in the ICO files. Alternatively, the ICO may delegate completion of the LOCD to the NF. If an enrollee is in the long term care facility at the time of the ICO enrollment effective date, the ICO may adopt the long term care facility's LOCD through the LOCD end date or until there is a significant change in condition, whichever is sooner. The Freedom of Choice form related to the adopted LOCD should be retained in the ICO files.
4. When the enrollee resides in a long term care facility at the time of the ICO enrollment effective date, then transfers to a different long term care facility after the ICO enrollment effective date, the ICO must conduct a new LOCD or adopt a current existing LOCD through the end date or until a significant change in status occurs. Alternatively, the ICO may delegate completion of the LOCD to the NF.
5. If an ICO conducts/delegates or adopts an LOCD, and the enrollee goes

to the hospital and then returns directly to the long term care facility, another LOCD does not need to be conducted for the readmission unless the ICO expects that the enrollee no longer meets LOCD criteria or meets through a different door. The same is true if the individual is enrolled in the MI Health Link HCBS Waiver, goes to the hospital for an acute condition, and then returns to the community and remains on the waiver. If the same LOCD is used after the hospital or long term facility admission, the ICO must ensure the individual still meets through the same Door. If after the discharge, the individual now meets through a different door, the ICO must conduct another LOCD and enter it into CHAMPS.

12. The LOCD system now has the functionality to allow ICOs to view adopted LOCDs that were conducted by other providers prior to the ICO enrollment.
13. If another provider conducts an LOCD on top of a current and valid ICO LOCD when the member remains in the ICO, the ICO may adopt and utilize the end date of the 2nd provider's LOCD if they agree with the door.

4.4 HCBS Waiver LOCDs

1. Initial Waiver Enrollment

- LOCD must be conducted and entered in CHAMPS within 14 days from learning about the individual's potential need for waiver services. (LOCD must be conducted prior to the start of waiver services.)
- HCBS Waiver materials must be submitted to MDHHS via CHAMPS within 30 days of the LOCD being conducted by the ICO.
- LOCDs must be renewed during the waiver enrollment review period as needed based on End Dates in CHAMPS.
- If no LOCD is in CHAMPS when the waiver enrollment is submitted to CHAMPS the system will result an error and not allow the enrollment to be submitted.

2. Ongoing Waiver Eligibility

- LOCDs must be conducted at least annually.

4.5 Obtaining Access to CHAMPS LOCD System

- To gain access to the CHAMPS LOCD system, ICO staff (or their contractors) must obtain access to CHAMPS. The CHAMPS webpage is located here: Community Health Automated Medicaid Processing

System (CHAMPS)

- Once staff have obtained the CHAMPS link in MILogin, the Domain Administrator at each ICO will be able to provide them with the "LOCD-TECH-CFE" profile.

- The MDHHS LOCD webpage offers a user guide with instructions/information on how to organize and sort My Inbox messages in Excel, manage LOCD list pages, check LOCD end dates, upload documentation, and examples of supporting documentation. The webpage can be found here Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

5. State Plan Personal Care Services

Personal care services must be provided by the ICO according to procedures and protocol provided by the State. The following process and procedure codes must be followed for billing and submitting encounters for personal care services:

- Use procedure code T1019 for personal care services, per 15 minute increments.
- For personal care supplement payment (see section related to personal care supplement payment starting on page 29 for further detail):
    - The ICO must use the invoice provided by MDHHS. The ICO must give this invoice to Adult Foster Care and Homes for the Aged providers for billing purposes. This invoice will be returned to the ICO, and the ICO will pay the personal care supplement to the provider as appropriate. There must be an invoice for each enrollee residing in one of these settings.
    - The ICO will need to track the amount and date paid to the Adult Foster Care home or Home for the Aged for each enrollee.
    - For personal care supplement payments, the ICO should use procedure code "T1019" (personal care services, per 15-min increments) with modifier "CG" (policy criteria applied).
    - The ICO may find Place of Service code "14" (Group Home) applicable in Loop 2300.
    - The ICO must submit encounters for each enrollee based on the information on the invoice and using the codes provided by MDHHS.
- Encounters will require a diagnosis code as well. For ICD-9, MDHHS recommends "V60.89" (Other specified housing or economic circumstances) or "V60.4" (No other household member able to render care). For ICD-10, MDHHS recommends "Z74.1" (Need assistance with personal care) or "Z74.2" (No other household member able to render care).

5.1 Overview of Personal Care Services

Personal care is a Medicaid State Plan service provided in the MI Health Link program to address physical assistance needs and enable individuals to remain in their homes by avoiding or delaying the need for long term care in an institutional setting. These services are furnished to enrollees who are not currently residing in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities or institution for mental illness and are provided in accordance with 42 CFR 440.167.

Personal care services are available to persons who require hands-on assistance in activities of daily living (ADLs): eating, toileting, bathing, grooming, dressing, mobility, and transferring, as well as direct assistance in instrumental activities of daily living (IADL), including personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration.

Personal care services are available to people living in their own homes or the home of another. Services also may be provided outside the home, for the specific purpose of enabling a beneficiary to be employed.

An individual assessment assists in identification of service needs. People with more basic needs may be served by adults who are capable of communicating with the enrollee and being responsive to his/her needs. People with more complex needs or more specialized problems must be served by individuals who can demonstrate their competence through experience or training. See Complex Care Needs section below.

Providers shall be qualified individuals who work independently or contract with or are employed by an agency. The Integrated Care Organization (ICO) will arrange for personal care services to be provided by independent care providers of the enrollee's choice, through employment or the use of a fiscal intermediary, an agency of choice, or a Home Help or other care agency, if the individual meets MDHHS qualification requirements, to provide personal care services. Enrollees who currently receive personal care services from an independent care provider may elect to continue to use that provider or select a new provider so long as that provider meets the State qualifications. Paid family caregivers will be permitted in accordance with Michigan's State Plan for personal care services. Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76.

ICOs determine the amount, scope and duration of service provision based on the clinical observations of the enrollee's needs during the in-person Personal Care Assessment. Additional hours of personal care are provided for complex care needs as described further in this guide.

5.2 Assessment and Reassessment Requirements

Initial Assessment

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the enrollee may need personal care services. If the ICO Care Coordinator believes the enrollee may be eligible for MI Health Link personal care services, the Care Coordinator will conduct the Personal Care Assessment. The in-person comprehensive assessment is the basis for determining and authorizing the amount, scope and duration and payment of services. The Personal Care Assessment will be completed in-person in the enrollee's place of residence. Assessment may also include an interview with the individual who will be providing personal care services or any persons the enrollee wishes to include.

Reassessment

The ICO will reassess the enrollee's needs every six months, or sooner to determine if there is a change of functional and/or health status. The ICO will review in-person the existing Personal Care Assessment to determine if there has been a change in the enrollee's functional or health status, requiring the Personal Care Assessment to be completed.

- If the existing assessment and approved services continue to meet the enrollee's needs, the results of the reassess must be documented in the Integrated Care Bridge Record.
- If there is a change of functional and/or health status, a new in- person Personal Care Assessment must be completed. This would start a new six-month schedule.
    - **Note:** If the enrollee, provider, guardian or other legal representative believes the enrollee's functional and/or health status has changed before the time of reassessment, the ICO must complete a new Personal Care Assessment. This would start a new six-month schedule.

5.3 ADL/IADL Rank

ADL and IADL activities are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale, where 1 is totally independent and 5 requires total assistance.

1. Independent.
   Performs the activity with no human assistance.

2. Verbal assistance.
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some human assistance.
   Performs the activity with some direct physical assistance and/or assistance technology.

4. Much human assistance.
   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent.
   Does not perform the activity even with human assistance and/or assistance technology.

An enrollee must be assessed with at least one ADL in order to be eligible to receive personal care services. Payments for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater. In addition, the enrollee must have an ADL functional ranking of three (3) or greater to be eligible for IADL services. Once an enrollee is determined eligible for personal care services, his or her authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

The following charts provide guidance when completing a comprehensive assessment.

ACTIVITIES OF DAILY LIVING (ADL)

Eating - helping with the use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, swallowing foods and liquids, cleaning face and hands after a meal.

1	No assistance required.
2	Verbal assistance or prompting required. Enrollee must be prompted or reminded to eat.
3	Minimal hands-on assistance or assistive technology needed. Help with cutting up food or pushing food within reach; help with applying assistive devices. The constant presence of another person is not required.
4	Moderate hands-on assistance required. Enrollee has some ability to feed self but is unable to hold utensils, cup, or glass and requires the constant presence of another person while eating.
5	Totally dependent on others in all areas of eating.

Toileting - helping on/off the toilet, commode or bedpan; emptying commode, bed pan or urinal, managing clothing, wiping and cleaning body after toileting, cleaning ostomy and/or catheter tubes/receptacles, applying diapers and disposable pads. May also include catheter, ostomy or bowel programs.

1	No assistance required.
2	Verbal direction, prompting or reminding is required.
3	Minimal hands-on assistance or assistive technology needed with some activities. The constant presence of another person while toileting is not necessary.
4	The enrollee does not carry out most activities without human assistance.
5	Totally dependent on others in all areas of toileting.

Bathing - helping with cleaning the body or parts of the body using a tub, shower or sponge bath; including getting a basin of water, managing faucets, soaping, rinsing and drying, or helping shampoo hair.

1	No assistance required. Bathes self safely without help from another person.
2	Bathes self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.
3	Minimal hands-on assistance or assistive technology required to carry out task. Generally, bathes self but needs some assistance with cleaning hard to reach areas; getting in/out of tub/shower. Enrollee is able to sponge bath but another person must bring water, soap, or towel. Enrollee relies on a bath or transfer bench when bathing. The constant presence of another is not required.
4	Requires direct hand- on assistance with most aspects of bathing. Would be at risk if left alone.
5	Totally dependent on others in all areas of bathing.

Grooming - Maintaining personal hygiene and a neat appearance; including the combing/brushing of hair, brushing/cleaning teeth, shaving, and fingernail and toenail care.

1	No assistance required.
2	Grooms self with direction or intermittent monitoring. May need reminding to maintain personal hygiene
3	Minimal hands-on assistance required. Grooms self but needs some assistance with activities of personal hygiene.
4	Requires direct hands-on assistance with most aspects of grooming. Would be at risk if left alone.
5	Totally dependent on others in all areas of grooming.

Dressing - Putting on and taking off garments; fastening and unfastening garments/undergarments, assisting with special devices such as back or leg braces, elastic stockings/garments and artificial limbs or splints.

1	No assistance required.
2	Enrollee is able to dress self but requires reminding or direction in clothing selection.
3	Minimal hands-on assistance or assistive technology required. Enrollee unable to dress self completely (i.e. tying shoes, zipping, buttoning) without the help of another person or assistive device.
4	Requires direct hands on assistance with most aspects of dressing. Without assistance would be inappropriately or inadequately dressed.
5	Totally dependent on others in all areas of dressing.

Transferring - Moving from one sitting or lying position to another. Assistance from the bed or wheelchair to the sofa, coming to a standing position and/or repositioning to prevent skin breakdown.

1	No assistance required.
2	Enrollee is able to transfer but requires encouragement or direction.
3	Minimal hands-on assistance needed from another person for routine boosts or positioning. Enrollee unable to routinely transfer without the help of another or assistive technology such as a lift chair.
4	Requires direct hands-on assistance with most aspects of transferring. Would be at risk if unassisted.
5	Totally dependent on others for all transfers. Must be lifted or mechanically transferred.

Mobility - Walking or moving around inside the living area, changing locations in a room, assistance with stairs or maneuvering around pets, or obstacles including uneven floors.

1	No assistance required even though the enrollee may experience some difficulty or discomfort. Completion of the task poses no risk to safety.
2	Enrollee is able to move independently with only reminding or encouragement. For example, needs reminding to lock a brace, unlock a wheelchair or to use a cane.
3	Minimal hands-on assistance required for specific maneuvers with a wheelchair, negotiating stairs or moving on certain surfaces. Without the use of a walker or pronged cane, enrollee would need physical assistance.
4	Requires hands-on assistance from another person with most aspects of mobility. Would be at risk if unassisted.
5	Totally dependent on other for all mobility. Must be carried, lifted or pushed in a wheelchair or gurney at all times.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Taking Medication - Taking prescribed and/or over the counter medications

1	No assistance required.
2	Enrollee is able to take all medications but needs reminding or direction.
3	Enrollee is able to take all medication if someone assists in measuring dosages or prepares administration schedule.
4	Enrollee is able to take some medication if another person assists in preparation but needs someone to assist in administering other medications.
5	Totally dependent on another. Does not take medication unless someone assists in administering.

Meal Preparation - Planning menus, washing, peeling, slicing, opening packages/cans, mixing ingredients, lifting pots/pans, reheating food, cooking, safely operating stove, setting the table, serving the meal, and washing/drying dishes and putting them away.

1	No assistance required.
2	Verbal direction, prompting or reminding is required for menu planning, meal preparation or clean up.
3	Minimal hands-on assistance required for some meals. Enrollee is able to reheat food prepared by another and/or prepare simple meals/snacks.
4	Requires another person to prepare most meals and do clean-up.
5	Totally dependent on another for meal preparation.

Shopping - Compiling a list, managing cart or basket, identifying items needed, transferring items to home and putting them away, phoning in and picking up prescriptions. Limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for the health and maintenance of enrollee.

1	No assistance required.
2	Verbal direction, prompting or reminding is required for shopping.
3	Minimal hands-on assistance required for some tasks (grocery shopping) but enrollee can compile a list and go to nearby store for small items.
4	Requires hands-on assistance from another person with most aspects of shopping but enrollee is able to accompany and select needed items.
5	Totally dependent on another for shopping.

Laundry - Gaining access to machines, sorting, manipulating soap containers, reaching into the machine for wet/dry clothing, operating the machine controls, hanging laundry to dry, folding and putting away.

1	No assistance required.
2	Performs all tasks but needs reminding or direction to do laundry on a regular basis or to do it properly.
3	Minimal hand-on assistance required with some tasks but is able to do most laundry without assistance
4	Requires hands-on assistance from another person with most aspects of laundry. Is able to perform some laundry tasks such as folding small clothing items or putting clothes away.
5	Totally dependent on another for laundry.

Light Housecleaning - Sweeping, vacuuming and washing floors, washing kitchen counters and sinks, cleaning the bathroom, changing bed linens, taking out garbage, dusting, cleaning stove top, and cleaning refrigerator

1	No assistance required
2	Performs all tasks but needs reminding or direction from another.
3	Requires minimal assistance from another for some tasks due to limited endurance or limitations in bending, stooping or reaching.
4	Requires assistance for most tasks although enrollee is able to perform a few simple tasks alone such as dusting and wiping counters.
5	Totally dependent on another for housecleaning.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are delivered by a non-paid caregiver (i.e., a family member) or the enrollee refuses the services, the enrollee would still be eligible to receive IADL services if assessed at a level 3 or greater.

> Example: Ms. Smith is assessed at a level 4 for bathing. If she refuses to receive assistance or her daughter agrees to assist her at no charge, Ms. Smith would be eligible to receive assistance with IADLs if the assessment determines a need at a level 3 or greater.

Note: If an enrollee uses adaptive equipment to assist with an ADL, and without the use of this equipment the person would require hands-on care, the enrollee must be ranked a level 3 or greater on the functional assessment. This enrollee would be eligible to receive personal care services. Examples of adaptive equipment include, but are not limited to walkers, wheelchairs, canes, reachers, lift chairs, bath benches, grab bars and handheld showers.

> Example: Mr. Jones utilizes a transfer bench to get in and out of the bathtub, which allows him to bathe himself without the hands-on assistance of another. The ICO must rank Mr. Jones a level 3 or greater under the functional assessment. Mr. Jones would be eligible to receive personal care services.

5.4 Reasonable Time and Task

The ICO must ensure that adequate minutes of services are provided to meet the beneficiary's needs. The Reasonable Time Schedule (below) are provided as a **guide**. The ICO may authorize more minutes per ADL as needed to meet the enrollee's needs based on observation of the enrollee's abilities during the in-person assessment.

For example, bathing ranking and the recommended times are as follows:

Activity	**Rank**	**Minutes per day**
Bathing	3	16
Bathing	4	18
Bathing	5	22

The ICO may provide higher or lower hours than shown on the Reasonable Time Schedule (RTS). Possible reasons for using higher hours include, but are not limited to, incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include, but are not limited to, shared living arrangements (specifically for IADLs except for administering medications) and responsible relatives able and available to assist.

The ICO must provide adequate hours of service to meet the enrollee's needs even when that goes above the RTS. If the enrollee's needs go above the Reasonable Time Schedule, the ICO must add justification/verification to the assessments and IICSP to document the reasons for the extra needs.

Time and task is only for ADL and IADL services for the enrollee. Care for an enrollee's pet does not count towards time and task.

Activities of Daily Living

The Reasonable Time Schedule (RTS) table includes the following reasonable times for completing ADL tasks:

Activity	Rank	Minutes per day assuming 7 days a week
Bathing	3 4 5	16 18 22
Grooming	3 4 5	8 10 12
Dressing	3 4 5	14 16 18

Toileting	3 4 5	22 26 28
Transferring	3 4 5	6 8 10
Eating	3 4 5	44 50 56
Mobility	3 4 5	14 16 18

Instrumental Activities of Daily Living

These activities require a ranking of 3, 4 or 5, but the reasonable times allotted are the same for all ranks. There are monthly maximum hour limits on all instrumental activities of daily living (IADL) except medication. The limits are as follows:

- Five hours/month for shopping.
- Six hours/month for light housework.
- Seven hours/month for laundry.
- 25 hours/month for meal preparation.

If the enrollee does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for each task. Assessed hours for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as personal care services are **only** for the benefit of the enrollee.

Note: This does not include situations where others live in adjoined apartments/flats or in a separate home on shared property and there is no shared, common living area.

In shared living arrangements, where it can be **clearly** documented that IADLs for the eligible enrollee are completed separately from others in the home, hours for IADLs do not need to be prorated.

Example: The enrollee has special dietary needs and meals are prepared separately; the enrollee is incontinent of bowel and/or bladder and laundry is completed separately; the enrollee's shopping is completed separately due to special dietary needs and food is purchased from specialty stores; etc.

Time and task is only for ADL and IADL services for the enrollee. Care for an enrollee's pet does not count towards time and task.

5.5 Travel Time to Shop and Complete Laundry

Providers must be allowed to receive payment for travel time to shop for food, prescriptions, medical necessities and household items required specifically for the health and maintenance of the enrollee. Payment for travel cannot exceed the number of approved trips for these tasks. Travel time for laundry will be paid when the caregiver is required to travel away from a client's home or their own home to perform this task.

Individual providers may receive payments for travel time up to:

- 2 round-trips each week for shopping.
- 2 round-trips each week for laundry.

Travel time for shopping and laundry will be determined by the ICO at initial assessment and re-evaluated every six months. For enrollees currently receiving Personal Care Services, travel time for shopping and laundry will be determined during the next visit with the enrollee, but not later than the next review. The amount of time approved by the ICO will be based on information obtained from the enrollee and the provider. Provider time needed to complete a client's laundry will be included with the time needed to travel to the nearest laundry facility. Provider time for shopping must be incurred in the local area where the client residence is located. ICOs must consider the member's wishes, dietary needs, religious and cultural preferences and beliefs, as well as other possible exceptions, when authorizing travel time for shopping.

For enrollees currently receiving Personal Care Services, payment for the provider's travel time will be made retroactively to March 1, 2018, once the assessment has been completed. The amount allocated for travel time will be based on normal, routine travel for the task being performed. Any permanent change in the amount of travel time must be reported to the ICO within ten calendar days. For example, this can occur if the member has a change in residence or a different store or laundromat must be visited because of closure or change in member preference. The payment to cover travel time for shopping and laundry will be added in the regular payment to the provider. This benefit will be included in the 2018 Medicaid capitation rates.

5.6 Complex Care Needs

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed for enrollees whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or

enrollee may be required in order to perform. After specific instruction and/or training, a return demonstration of the complex care task is needed to determine competency of the provider.

- Eating and feeding
- Catheters or legs bags
- Colostomy care
- Bowel program
- Suctioning
- Specialized skin care
- Range of motion exercises
- Peritoneal dialysis
- Wound care
- Respiratory treatment
- Ventilators
- Injections

The Reasonable Time Schedule (RTS) table includes the following reasonable times for completing certain complex care tasks:

Activity	Daily	Monthly
1. Eating or Feeding Assistance		
- Blended meals & throat massage – 45 minutes/meal X 3	2.25 hrs	67.5 hrs
- Feeding tube or supplemental food bag:		
○ if 20 minutes each x 4 in 24 hour period	1.33 hrs	40 hrs
○ if 20 minutes each x 6 in 24 hour period	2 hrs	60 hrs
2. Catheters or Leg Bags (Toileting)		
- In-dwelling (Foley), 10 minutes every 4 hours	1 hr	30 hrs
- Intermittent, 15 minutes every 4 hours	1.5 hrs	45 hrs
3. Colostomy Care (Toileting)		
- If 20 minutes once a day	.33 hrs	10 hrs
- If 20 minutes twice a day	.66 hrs	19.8 hrs
Use the hours in numbers 2 and 3 in place of toileting if both a catheter and colostomy care is needed. If only one is needed then some toileting hours may be included in the regular reasonable time schedule.		

4. Bowel Program (used mainly for quadriplegics) (Toileting)	2 hrs every other day	30 hrs
5. Suctioning (Eating) During meals or as needed Minimum – 10 minutes every 2 hours	2 hrs	60 hrs
6. Specialized Skin Care (Transferring) - Turning at night – 10 minutes every 2 hours for 10 hours - Massage to prevent decubital ulcers – 15 minutes per day	.83 hrs .25 hr	25 hrs 7.5 hrs
7. Range of Motion Exercises (Mobility) - If 30 minutes once a day - If 30 minutes twice a day	.5 hr 1 hr	15 hrs 30 hrs

Time and Task

The ICO Care Coordinator will allocate time for each task assessed a rank of 3 or greater, based on interviews with the enrollee and provider, observation of the enrollee's abilities and use of the RTS **as a guide**. The ICO must provide adequate hours of service to meet the enrollee's needs even when that goes above the RTS. If the enrollee's needs go above the RTS, the ICO must add justification/verification to the assessments and IICSP to document the reasons for the extra needs.

An assessment of need, at a ranking of 3 or greater, does not automatically guarantee the maximum allotted time allowed by the RTS. The ICO Care Coordinator must assess each task according to the actual time required for its completion.

> Example: An enrollee needs assistance with cutting up food. The ICO Care Coordinator would only pay for the time required to cut the food and not the full amount of time allotted under the RTS for eating.

Time and task is only for ADL and IADL services for the enrollee. Care for an enrollee's pet does not count towards time and task.

5.7 Provider Qualifications

A criminal history screen must be conducted for all personal care providers. In addition, the provider's ability to meet the following minimum qualifications must be determined:

Age: The provider must be 18 years and older.

Ability: To follow instructions and personal care procedures.

To perform the services required.

To handle emergencies.

Physical Health:	The provider's health must be adequate to perform the needed services.
Knowledge:	The provider must know when to seek assistance from appropriate sources in the event of an emergency.
Personal Qualities:	The provider must be dependable and able to meet job demands.
Training:	The provider must be willing to participate in available training programs if necessary.

If personal care is needed for basic needs and the provider qualifications can be determined via phone, an in-person interview may not be required. There are situations when a return demonstration may be needed if this is a new care provider to the enrollee. For example, the use of a Hoyer lift. If this is a current care provider who has been using a Hoyer lift and the enrollee confirms that the lift is being used without problems, a return demonstration may not be necessary. If this is a new provider to an enrollee, a return demonstration may be necessary to ensure proper use of the lift and safety of the enrollee.

ICO Care Coordinator may use discretion in determining if a basic care need return demonstration is required.

In addition to a criminal history screen and meeting minimum requirements, a return demonstration of the complex care task is needed to determine competency of the provider.

Effective August 1, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76.

5.8 Provider Payment and Rates

Per the continuity of care requirements, after an individual enrolls in MI Health Link, the ICO must maintain the individual's current personal care providers and amount, scope and duration of services until the IICSP is reviewed and updated and providers are secured with enrollee approval. An ICO should use the Home Help Payment Schedule to continue paying Home Help providers as scheduled. An ICO should follow this schedule until the ICO and personal care provider agree upon a new payment schedule. The ICO must publish a pay cycle and adhere to the requirements of paying these claims on the next available pay cycle date. The Home Help Payment Schedule can be found at Home Help Provider Payment Schedule 2025

Effective October 1, 2024, ICOs are no longer required to pay personal care providers equal to or more than what is noted in the Individual and Agency County Rates. ICOs are not required to match Home Help rates for Direct Care Worker wages.

Please be aware that the November 1, 2024, Home Help individual caregiver rate adjustment was based on the verified increase in the state minimum wage that goes into effect on February 21, 2025. For reference, the Individual and Agency County Rates can be found at the link below.

COUNTY RATES

(Note: Effective October 1, 2019, MDHHS moved to one statewide rate for all agency providers.)

Payment rates for personal care services are established by the ICO. Tasks are assigned minute values which are converted to hours and billed as a total at the end of the ICO's preferred pay period. Reimbursement is subject to any state or federal laws that may be applicable in the future.

For Personal Care Supplement Payments to licensed AFCs and HFAs see section 5.13.

5.9 Responsible Relatives and Guardians

Adult children (18 years or older) may provide personal care services to a parent, and legal guardians may provide personal care services, as well. A person with financial responsibility for an enrollee may not be paid to provide personal care services. (Financial responsibility means: one individual is legally obligated to provide for the other person from their own money. Simply having the responsibility/authority to direct another individual's funds to pay bills, meet financial obligations such as conservator, representative payee, and guardian does not constitute "financially responsible." The only exclusion would be if the letters of authority issued by Probate court specifically state the guardian or conservator is financially responsible.) Spouses **cannot** be paid to provide personal care services as they are considered responsible relatives.

Couples who are separated must provide verification that they are no longer residing in the same home ("unavailable" as defined below). Verification may include their driver's license, rent receipt or utility bill reflecting their separate mailing address. A spouse who is legally separated from a spouse cannot be paid to provide personal care services. ADLs may be approved when an enrollee's spouse is unavailable or unable to provide these services.

Note: Unavailable means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. Unable means the responsible person has disabilities of their own which prevent them from providing care.

Do not approve shopping, laundry, or light housecleaning, when a responsible relative of the enrollee resides in the home, unless they are unavailable or unable to provide these services.

Example: Mrs. Smith is in need of personal care services. Her spouse is employed and is out of the home Monday through Friday from 7 AM to 7 PM. Hours for shopping, laundry or house cleaning would not be approved as Mr. Smith is responsible for these tasks.

Example: Mrs. Jones is in need of personal care services. Her spouse's employment takes him out of town Monday through Saturday. Hours for shopping, laundry or house cleaning may be approved.

5.10 Personal Care Services and the MI Health Link 1915(c) Waiver

If an enrollee ranks at a level 1 or 2, he or she will not be eligible for State Plan Personal Care Services through MI Health Link. If an individual ranks at a level 2, he or she may be eligible for ADL assistance through the MI Health Link HCBS waiver Expanded Community Living Supports (ECLS) benefit if the enrollee requires prompting, cueing, guiding, teaching, observing, or reminding to complete ADLs. An enrollee can receive IADL assistance if he or she qualifies for ECLS due to a need for prompting, cueing, guiding, etc. to complete ADLs. The ICO Care Coordinator must assure the Nursing Facility Level of Care Determination Tool is performed to determine if the enrollee qualifies to receive MI Health Link HCBS waiver services.

ECLS may be provided in addition to State Plan Personal Care Services if the enrollee requires hands-on assistance with some ADLs, as covered under Personal Care Services, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs and IADLs independently to ensure safety, health, and welfare of the enrollee. Refer to the MI Health Link HCBS waiver and supporting documentation for additional information. Personal Care Services and ECLS may also be provided for the same ADLs or IADLs but at different times during the day.

Potential Scenarios for State Plan Personal Care Services and MI Health Link 1915(c) waiver

	Enrollee has a need for	**Services that could be provided**
Scenario 1	Hands-on assistance with ADLs	State Plan Personal Care Services
Scenario 2	Hands-on assistance with ADLs and IADLs	State Plan Personal Care Services
Scenario 3	Prompting, cueing, observing, guiding, teaching, and /or reminding related to ADLs and is enrolled in the MI Health Link HCBS waiver	Expanded Community Living Supports

Scenario 4	Prompting, cueing, observing, guiding, teaching, and /or reminding related to ADLs and IADLs and is enrolled in the MI Health Link HCBS waiver	Expanded Community Living Supports
Scenario 5	Hands-on assistance with some ADLs (and maybe some IADLs), and a need for prompting, cueing, observing, guiding, teaching, and /or reminding for other ADLs (and maybe some IADLs) and is enrolled in the MI Health Link HCBS) waiver	State Plan Personal Care Services AND Expanded Community Living Supports

5.11 Mandatory and Permissive Exclusions – Letters and Notification Processes

a. Appendix 8: Notification Process for Mandatory Exclusions of Personal Care Providers
b. Appendix 9: Process for the OIG Termination and Summary Suspension of a Current Provider
c. Appendix 10: Notification Process for Permissive Exclusions

Email Attachments:

- Beneficiary Letter for Mandatory Exclusions
- Acknowledgement of Personal Care Provider Selection
- Advanced Action Notice for Mandatory Exclusion
- Adequate Action Notice for Mandatory Exclusion

5.12 Continuity of Care for Personal Care Services

For individuals enrolled with the ICO, then disenrolling, then returning to the ICO, the ICO must allow a continuity of care period for personal care services. The ICO must continue services based on the personal care services received at the time of the disenrollment. If the beneficiary did not receive personal care services external to the ICO during the period of ICO disenrollment, the beneficiary can be out of the ICO for 3 months OR as long as the personal care assessment has not expired, whichever is longest, to receive continuity of care. If personal care services were received external to the ICO during the period of ICO disenrollment, the ICO must honor the most recent amount, scope and duration of the services received during the disenrollment. The continuity of care period is as follows:

- 180 days for individuals receiving services through the PIHP under the Managed Specialty Services and Supports Program (MSSSP) or Habilitation Supports Waiver,
- 90 days for all other individuals.

The ICO can reassess a member's current condition with the Personal Care Assessment and provide the care the member requires per their current needs at any time during the continuity of care period.

5.13 Personal Care Supplement for Enrollees in an Adult Foster Care Home or Home for the Aged and Unlicensed Congregate Residential Setting

For enrollees in a licensed Adult Foster Care (AFC) home or Home for the Aged (HFA), a flat monthly supplement rate is established annually by the state legislature for those Medicaid beneficiaries who, according to a standardized assessment, have a documented need for personal care services. The supplement rate is included in the ICO rates, and the ICOs will be required to pay it to adult foster care homes and home for the aged providers for MI Health Link enrollees.

AFCs or HFAs receive payment from the ICO if the enrollee meets all three of the following criteria

- Receives Medicaid
- Lives in a Michigan **licensed Adult Foster Care Home or Home for the Aged**
- Scores at a 2 or above on the Personal Care Assessment for activities of daily living and/or a 5 for medication administration.

Note: If the client is ranked a '1' (independent) with ADLs and does not take any medication, they are considered domiciliary care and the home would not qualify for the personal care supplement.

The Personal Care Supplement rate can be found in the Adult Services Manual (ASM) Section 077: ADULT SERVICES MANUAL TABLE OF CONTENTS. The amount can be prorated for partial month stays in an AFC or HFA. The rate may potentially change when the legislature establishes the annual MDHHS budget. The ICO cannot provide the enrollee both State Plan Personal Care Services and the Personal Care Supplement simultaneously.

Enrollees residing in an AFC or HFA may not receive the regular State Plan Personal Care benefit, paid on an hourly or per unit basis. For enrollees residing in AFCs or HFAs, the payment for personal care is limited to the Personal Care Supplement **only**. Similarly, because the Personal Care Supplement covers ranking of Level 2 (supervision, prompting, cueing for ADLs and IADLs), the AFC/HFA or enrollee may not receive payment for the Expanded Community Living Supports service through the HCBS Waiver in addition to the Personal Care Supplement.

ICOs were provided with an invoice form to use for the Personal Care Supplement payment. This invoice form must be shared with the AFC and HFA providers so they can bill ICOs for the payment.

Personal care supplements are not paid by ICOs in instances where the residential setting is certified as a specialized residential setting through BHDDA/PIHPs and the money for personal care services is paid to the setting through the PIHP capitation payment for Medicaid services. If a home has either (or both) a special certification of 'mentally ill' or 'developmentally disabled' then the home falls into the specialized residential setting category.

ICOs can conduct a LARA license look up utilizing the link below.

Statewide Search For Adult Foster Care / Homes for the Aged Facilities

The Personal Care Supplement must not be paid to settings that are not licensed by the State of Michigan as an AFC or HFA. Additionally, ICOs cannot pay hourly for personal care in settings that SHOULD be licensed except in the case of a Supported Independent Setting (SIP) (see below) See Section 21.13 for criteria to evaluate the setting and steps the ICO should take if a setting that should be licensed is not.

- **Supported Independent Setting (SIP):** homes supervised by Community Mental Health (CMH) with three or four residents **all** receiving CMH services. SIP homes do not need to be licensed unless one of the residents is not receiving CMH services. Residents of a SIP home could qualify for personal care services. The person who owns, rents, or leases the SIP home cannot be the individual caregiver or agency provider of the Home Help client.

6. Resident Care Agreements in Adult Foster Care Licensed Settings

Licensed Adult Foster Care (AFC) settings require Resident Care Agreements to indicate care needs, payment for room and board and services, among other things. These agreements must be signed by the resident or his/her legal representative and the ICO as soon as possible since the ICO is responsible for paying the personal care supplemental payment. Per R 400.14301, it is a requirement for this agreement to be reviewed with the beneficiary or the beneficiary's designated representative and responsible agency, at least annually. If information within the agreement did not change, the ICO will not need to complete a new agreement; however, we expect the licensee (AFC provider) to have a process to document that the agreement was reviewed again. The rule does not specify how to document a review of the agreement so how the licensee documents this may vary. Some examples of documentation include having all parties sign the previous agreement again, or initial and date the previous agreement. At any point if there is a change to the agreement, a new form must be completed and signed by all parties upon changing the agreement.

7. Service Animals

ICOs may provide a $20 monthly stipend for care and maintenance of a service animal, paid directly to the enrollee. The Americans with Disabilities Act (ADA) defines service animals as those that are individually trained to do work or perform tasks for people with disabilities. This benefit covers dogs and miniature horses that meet the ADA definition of service animal.

The benefit for maintenance costs of a service animal may be authorized if all of the following conditions are met:

- The client is receiving personal care services.
- The client is certified as disabled due to a specific condition such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, among others.
- The service animal is trained to meet the specific needs of the client relative to his or her disability.
- The service animal does not have to be professionally trained, and proof of training must not be requested.

- The tasks performed by the service animal are for the client.

Examples of tasks performed by a service animal may include, but are not limited to, the following:

- Guiding enrollees who are blind
- Alerting enrollees who are deaf
- Pulling a wheelchair
- Alerting and protecting enrollees with a seizure disorder
- Reminding enrollees with mental illness to take prescribed medications
- Calming enrollees with Post-Traumatic Stress Disorder (PTSD) during an anxiety attack (an enrollee still needs to receive a personal care service to qualify for the monthly stipend for care and maintenance of a service animal)

The IICSP must document that the service animal will be used primarily to meet specific needs of the client relative to his or her disability. The ICO may ask what tasks the service animal performs for the client but cannot request a demonstration of the tasks.
No verification of expenses or services provided by the service animal is required. The need for the service animal is assessed by the ICO during an in-person visit with the enrollee. If the enrollee is eligible for the stipend, the payment is authorized for six months, and payment is made directly to the enrollee. The need for the stipend must be reassessed every six months.

This benefit does not include general pets whose sole function is to provide comfort or emotional support.

This benefit is included in Medicaid capitation rates. MDHHS will annually collect stipend utilization/payment data from ICOs. Since there are no available procedure codes for this benefit, MDHHS will send ICOs a template for reporting this information.
The template will include the following elements: Beneficiary ID, Beneficiary first/last name, amount paid by month, and total annual amount paid.

Submission of the annual report to MDHHS will occur in January of the year following the reporting period. For example, for CY 2018, the report will be due in January of 2019. The annual report will be due the last Friday of January and should be submitted via FTP.

8. Enrollee Notification when ICO Care Coordinator Changes

The ICO must notify the enrollee via written correspondence when the ICO Care Coordinator changes per Section 2.5.3.3.5 of the Three-Way Contract. The enrollee must be notified in writing within two weeks of the ICO's knowledge of the reassignment of the Care Coordinator. The notification must include the name and contact information for the new Care Coordinator. This applies to both beneficiary (also legal representative or guardian)

requested changes and ICO related changes.

9. Beneficiary Moves Out of Service Area

ICOs should follow the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, located here: Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (rev. 10122023) when a beneficiary moves out of service area.

10. Critical Incident Reporting

A "Critical Incident" is defined as any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a MHL enrollee.

The ICO must report critical incidents to MDHHS and other required authorities according to state policies and processes and as approved in the MI Health Link HCBS waiver application.

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

1. 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.

2. 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.

3. 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).

4. Physical abuse - The use of unreasonable force on an enrollee with or without apparent harm.

5. Use of Restraints, seclusions or restrictive interventions. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

6. 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.

7. 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.

    a. 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.

    b. 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:

    1. Revenge.
    2. To inflict humiliation.
    3. 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.

8. 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).

9. Verbal abuse - Intimidation or cruel punishment that causes or is likely to cause mental anguish or emotional harm.

10. 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.

11. Suspicious or Unexpected Death - That which does not occur as a natural outcome to a chronic condition (e.g., terminal illness, suicide) or old age. These incidents are often also reported to law enforcement.

12. Suicide Attempt: Non-fatal, self-injurious behavior with the intent to take one's own life. All suicide attempts must have interventions that include connecting the member to mental health services.

13. 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.

The ICO has first line responsibility for identifying, investigating, evaluating and follow-up of critical incidents that occur with enrollees as listed above. The ICO maintains policies and procedures defining appropriate actions to take upon suspicion or determination of abuse, neglect and exploitation. The ICO establishes 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 the ICO, provider agencies, individual workers, independent supports brokers and enrollees and their allies. MDHHS reviews and approves these reporting procedures as needed.

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 Health and Human Services Adult Protective Services (DHHS-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. The ICO 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 DHHS-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 DHHS-APS, must be maintained in the enrollee's case record.

The ICO 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.

The ICO is responsible for tracking and responding to individual critical incidents using the MI Health Link 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. The ICO is required to report the types of critical incidents and the responses to those incidents for each event within 30 days of the date of incident. Outcomes and resolutions for each incident must be reported within 30 days of the date of the incident if possible. If outcomes or resolutions extend beyond 30 days, ICOs must provide periodic updates in the system until the matter is resolved. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the ICO.

The ICO manages critical incidents at the local level. The ICO is responsible to receive reports of critical incidents and ensure the immediate health and welfare of the enrollee. The ICO must also report, at a minimum, to the following entities if the incident was not already reported to these entities:

1. Exploitation - Required to report to DHHS-APS, MDHHS-MHL CI database

2. Neglect - Required to report to DHHS-APS, MDHHS-MHL CI database

3. Verbal abuse - Required to report to DHHS-APS, MDHHS-MHL CI database

4. Physical abuse - Required to report to DHHS-APS, MDHHS-MHL CI database

5. Use of Restraints, seclusions or restrictive interventions- Required to report to DHHS-APS, MDHHS-MHL CI database

6. Sexual abuse - Required to report to DHHS-APS, MDHHS-MHL CI database

7. Theft – MDHHS-MHL CI database, law enforcement if the beneficiary chooses

8. Provider no shows, particularly when enrollee is bed bound all day or there is a critical need – MDHHS-MHL CI database

9. Illegal activity in the home with potential to cause a serious or major negative event - local authorities/police, MDHHS-MHL CI database

10. Worker consuming drugs/alcohol on the job – MDHHS-MHL CI database

11. 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-MHL CI database within two business days of the ICO receiving the notice.

12. Suicide Attempt – MDHHS-MHL CI database

13. Medication errors - MDHHS -MHL CI database

The ICO must begin to investigate and evaluate critical incidents with the enrollee within two business days of identification that an incident occurred. The ICO is expected to investigate a critical incident until the enrollee is no longer in danger and until the situation is resolved. 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 90 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.

The 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 DHHS-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 Michigan law, the ICO must notify MDHHS via the critical incident reporting system whether the incident was reported to DHHS-APS or other entities as required by the State.

The enrollee and any chosen family or allies are updated on the investigation as it progresses. The ICO shall 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.

When MHL enrollees are also receiving supports and services through the PIHP for behavioral health, intellectual/developmental disability, or substance use needs, ICOs and PIHPs should continue to report incidents that meet their respective program reporting requirements. In the event an ICO or PIHP identifies a critical incident for a shared member, coordination between the ICO and PIHP to assure an appropriate resolution of the incident may be required depending on the nature of the incident. (e.g. Critical Incident of physical abuse where the abuser is a personal care provider being paid by both the ICO for state plan personal care and the PIHP for HSW services as documented in the beneficiary's IICSP – In this instance, there would be a need for the ICO and PIHP to coordinate to assure appropriate measures are taken to identify another caregiver, as well as

report, investigate, and resolve, the critical incident through their respective processes.) ICOs and PIHPs should address expectations in their Coordinating Agreement for investigation and resolution of all ICO and PIHP reportable incident types since they differ across programs.

The ICO is required to ensure the incidents have been investigated as appropriate. Immediately after being notified that an incident occurred, the PIHP must report to the ICO any of the critical incident types mentioned above that are not already being reported through the PIHP's critical incident reporting system, the Office of Recipient Rights, DHHS- APS, or LARA. For incidents not already reported through the PIHP's reporting system, the ICO must enter the incident in the MI Health Link Critical Incident Reporting System. If the PIHP already reported the incident, the ICO does not need to report the same incident through the MI Health Link Critical Incident Reporting System.

MDHHS evaluates and trends the incident reports submitted by the ICO. Analysis of the strategies employed by the ICO 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 ICO as necessary to educate staff on abuse and to strengthen preventive interventions and strategies. The ICO must complete the critical incident training module(s) provided by MDHHS.

In addition to this Minimum Operating Standards document, materials and resources for critical incident reporting may be found at:

- Michigan Department of Health and Human Services - Adult Protective Services: Adult Protective Services

- Michigan Department of Licensing and Regulatory Affairs: Licensing and Regulatory Affairs

- Michigan Department of Licensing and Regulatory Affairs –Office of Child and Adult Licensing: Children and Adult Licensing Division Contact Information

The ICO need not report an enrollee's request for a provider change unless there is a serious reason for the change that falls under the above definition of a critical incident.

11. Assessments

- ICOs must follow requirements set forth in the MI Health Link Assessment Tools Overview chart. The chart is located on the MI Health Link website. The link to the website is: MI Health Link

  Assessments will be evaluated during annual audit review and findings will be shared with ICOs to identify any issues.
- BH Level II Assessments are valid for the following periods of time:
  - American Society of Addiction Medicine (ASAM) tool for members with substance use disorder needs: **one year from the initial completion date.**

  - Level of care utilization system (LOCUS) for members with behavioral health needs: **one year from the initial completion date.**
- Adopting Behavioral Health Level II Assessments:
  - A valid (i.e. Not expired) Level II Assessments (ASAM or LOCUS) may be adopted at the time the enrollee becomes effective with the ICO/PIHP. ASAM and LOCUS must be completed prior to the expiration date of the current assessment.
  - Biopsychosocial: May be adopted if the assessment is still valid (i.e. it has not yet expired) at the time the enrollee becomes effective with the ICO and PIHP and until the assessment expires. However, upon reassessment the appropriate Level II assessment per the Three-Way Contract (i.e. ASAM or LOCUS) must be completed.
- Level I Assessments:
  - Level I assessments may be completed via technological means such as Facetime or Skype. This method of conducting the assessment will be considered telephonic for quality measure or CMT reporting purposes and will **not** be considered "in-person".

12. MI Choice/PACE Transitions to MI Health Link

1. If MI Choice or PACE participants express a desire to disenroll from MI Choice or PACE to join MI Health Link, MDHHS will coordinate the transfer of individuals from MI Choice/PACE to MI Health Link, but MDHHS will evaluate each specific case prior disenrolling the individual from their program.
2. MDHHS will review the current plan of service, nursing facility level of care determination, and other assessment documentation to determine if the individual's needs may be met in MI Health Link without the individual losing Medicaid eligibility. Additionally, residential and non-residential settings will be evaluated by MDHHS to ensure immediate compliance with the HCBS Final Rule.
3. If, after the case evaluation by MDHHS, the individual would still like to enroll in MI Health Link and qualifies for the MI Health Link HCBS waiver, MDHHS will enroll the individual in the waiver with his or her chosen ICO. MDHHS will communicate the waiver enrollment to the ICO, and the ICO will provide the necessary services according to the individual's MI Choice/PACE records and MDHHS's recommendations until a new Level II assessment is due (one year after the start date on the MI Choice/PACE assessment) or the individual has a significant change in condition. The ICO is not required to conduct a new Level II assessment and NFLOCD immediately after the individual enrolls in MI Health Link.

13. Training

The ICO and other providers must complete required training as identified by MDHHS. Trainings will be added to the protocol as they are developed.

14. Hospice Services

Beginning November 1, 2016, in accordance with the Three-Way Contract changes, ICO members who choose to receive hospice services are permitted to remain enrolled in the ICO. ICOs are responsible for paying room and board for enrollees that receive hospice services in a long term care facility (i.e., nursing facility, County Medical Care Facility, hospital long term care unit). ICOs will receive the Tier 1 rate for enrollees receiving hospice services in a long term care facility setting. The Tier 1 rate includes the room and board for the long term care facility. The ICO must coordinate with the hospice provider for payment. The ICO will pay the hospice provider the room and board, and the hospice provider will pay the facility.

As a result of the Community Health Automated Medicaid Processing System (CHAMPS) Modernizing Continuum of Care (MCC) project, the DCH-1074 (Hospice Membership Notice) from will no longer be used for hospice admissions and discharges. ICOs will no longer need to send DCH-1074 forms to MDHHS since the previous process described in Version 4 of the MOS is no longer in use. Hospice provider documentation will become an electronic process as part of the new CHAMPS admission screens. The hospice provider must indicate the facility of residence on the Hospice Admission in CHAMPS so the ICO can receive the appropriate capitation rate. Please see policy bulletin MSA 17-46 for more information.

No Nursing Facility Level of Care Determination (LOCD) tools will need to be conducted for the time the enrollee is in hospice, unless he/she is also enrolling in the MI Health Link HCBS Waiver. In the case of the MI Health Link HCBS Waiver, the LOCD process is the same as usual.

There are hospice residential facilities under a different payment arrangement with State General Fund dollars. ICOs are not responsible for paying Medicaid room and board coverage in these residential facilities. The hospice residential facilities are listed below:

Contractor Name	AKA (Street Name)	NPI
Hospice At Home, Inc.	Hanson Hospice Center	1831186311
MidMichigan Visiting Nurse Association (formerly Hospice of Central Michigan, Inc.)	Woodland Hospice	1134101983
Edward W. Sparrow Hospital	Sparrow Hospice Services / Hospice House of Mid-Michigan	1619089539
Hospice of Muskegon County, Inc.	Harbor Hospice/ Leila & Cyrus Poppen Hospice Residence	1740283787
Faith Hospice	Trillium Woods / Holland Home	1790739282

Angela Hospice Home Care Inc.	Angela Hospice Care Center	1003818220
Hospice of Jackson	Allegiance Hospice Home	1992892301
Hospice of Lenawee, Inc.	Hospice of Lenawee Lenawee Home	1134250210
Hospice of Greater Kalamazoo	Hospice Care of Southwest Michigan/ -Rose Arbor Hospice Residence (Kalamazoo) -Glen Arbor Hospice Residence (Battle Creek)	1235197401
Visiting Nurse Association Health Services	Blue Water Hospice	1134124613
Hospice of Lansing	Stoneleigh Residence	1831170190
Munson Home Care	Munson Hospice House	1508982927
Marlette Regional Hospital (United Hospice Service Residence)	United Hospice Service Residence	1902981889

If there are other hospice residential facilities not included in the list above, ICOs are not responsible for paying room and board for those facilities. When paying claims, the ICO should check the PET code as the source of truth for place of residence and not deny a claim based only on the NPIs listed above. A hospice provider may provide services in both a residence and in the community/at a nursing facility using the same NPI. ICOs are responsible for paying for room and board if the PET code is ICO-HOSN or ICO-HOSC.

15. Hearing Aids

Effective 9/1/2018 coverage for hearing aids to Medicaid beneficiaries aged 21 and older was reinstated. ICOs must provide the benefit specified by the State plan and outlined in policy (1814-Hearing) but are not required to utilize the Minnesota Volume Purchase Hearing Aid contract. ICOs are able to establish their own contracts, vendor arrangements, and processes.

16. Individual Transitioning from LTC Facility to the Community

In order to ensure individuals transitioning from a long term care facility to the community do not lose Medicaid coverage when they are no longer in a nursing facility or enrolled in the HCBS Waiver, the following must occur:

- ICOs should communicate with the enrollee that the ICO needs to check with MDHHS for potential Medicaid eligibility problems if the individual leaves the

nursing facility.

- The ICO sends the enrollee's name, and Medicaid ID to the Enrollment mailbox MDHHS-MHL-Waiver@michigan.gov (MSA-MHL-Enrillment@michigan.gov). In the Subject line, please include "Transitioning." Please do not add any enrollee identifying factors in the subject line.
- MDHHS Integrated Care staff will send information to the MDHHS Eligibility Specialist to create a mock budget to determine if the enrollee will still have Medicaid eligibility if not in the nursing home.
- Once MDHHS Integrated Care staff receive an answer, MDHHS will notify the ICO. MDHHS does not anticipate a delay with this process.
- Once the ICO receives notification from MDHHS for the enrollee's eligibility the ICO should complete the necessary assessments to see if the enrollee qualifies for the waiver.
- If the enrollee qualifies for the waiver and would like waiver services, the ICO should submit a waiver enrollment in CHAMPS and check the transition from a facility box. This signifies to MDHHS staff that the enrollee is transitioning from the nursing facility.

17. Coverage of Fines, Fees or Taxes Levied on Properties

Medicaid funds must not be used to pay for any fines, fees or taxes that have been levied by a government entity on an enrollee's residential property for purposes of blight clean up or otherwise. ICOs are permitted to use their own funds to pay for these fines, fees or taxes if they choose to do so if the issues are a barrier to providing services.

18. Supplemental Services

These services are available to enrollees who do not meet nursing facility level of care or are not enrolled in the MI Health Link HCBS waiver.

18.1 Adaptive Medical Equipment and Supplies

Adaptive Medical Equipment and Supplies	
Description	Devices, controls, or appliances specified in the Individual Integrated Care and Supports Plan (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.
HCPCS Codes	Please see the list indicated below.
Units	Per item, unless otherwise specified.
Service Delivery Options	☑ Traditional ☐ Self-Determination

18.1.1. Minimum Standards for Service Delivery

1. It must be documented on the Individual Integrated Care and Supports Plan (IICSP) or Care Bridge record that the item is the most cost-effective alternative to meeting the enrollee's needs.
2. Items must meet applicable standards of manufacture, design, and installation.
3. There must be documentation on the IICSP or Care Bridge record that the best value in warranty coverage was obtained at the time of purchase.
4. Items must be of direct medical or remedial benefit to the enrollee, and this benefit must be documented in the enrollee's record.

5. 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).Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter.
6. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
7. Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the enrollee's physician.
8. The ICO shall not authorize payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not authorized by the FDA.
9. Examples include non-standard shower chairs (standard shower chair covered by state plan effective 1/1/2024), lift chairs, 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, mouth stick for TDD, foot massaging unit, talking timepiece, adaptive eating or drinking device, book holder, medical alert bracelet, adapted mirror, weighted blanket, and back knobber.
10. This service also includes the provision and installation of grab bars. Suction cup grab bars are prohibited. Please use HCPCS/Procedure Code S5199, remark 0113. Claims and encounters may be provided separately for the purchase of the item and the actual installation if they are provided separately.
11. If other items/supplies are provided under this service and require installation to be functional, the ICO must also pay for the installation. Use the most appropriate HCPCS code listed below and in Appendix 1 for the item.

12. For provider qualifications, refer to Appendix 7.The following HCPCS codes are approved for use under the Adaptive Medical Equipment and Supplies service:

    a. **A4931**, Oral Thermometer, Reusable, any type, each
    b. **A4932**, Rectal Thermometer, Reusable, any type, each
    c. **A9300**, Exercise Equipment
    d. **B4100**, Food thickener, administered orally, per ounce
    e. **B4150/BO**, Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit
        i. The ICO must use the BO modifier to indicate oral administration. The state plan covers formulae for tube feeding.
        ii. This product may be in any form, liquid, solid, powder, bar, etc.
        iii. For cans of nutritional supplement, one can equals one unit.
        iv. For bars of nutritional supplement, one bar equals one unit.
    f. **E0160**, Sitz type bath or equipment, portable, used with or without commode
    g. **E0161**, Sitz type bath or equipment, portable, used with or without commode, with faucet attachment
    h. **E0210**, Electric heat pad, standard
    i. **E0215**, Electric heat pad, moist
    j. **E0242**, Bathtub rail, floor base
    k. **E0315**, Bed accessory; board, table, or support device, any type
    l. **E0627**, Seat lift mechanism incorporated into a combination lift chair mechanism
    m. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric
    n. **E0745** Neuromuscular stimulator, electronic shock unit
    o. **E1300** Whirlpool, portable (over the tub type)
    p. **E1310** Whirlpool, non-portable (built-in type)
    q. **E1639**, Scale, each
    r. **S5162**, Emergency response system; purchase only
    s. **S5199**, Personal care item, NOS, each
        i. Use this code for items that the enrollee uses to perform activities of daily living (ADLs) or instrumental activities of

daily living (IADLs), or that assist the enrollee in the performance of ADLs or IADLs.

ii. This category shall exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.

iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.

iv. Standardized remarks are available.

t. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in "remarks"

i. Items in this category have a therapeutic use for the enrollee.

ii. The ICO must include a description of this item in the appropriate loop for approval of a claim.

iii. Standardized remarks are available.

iv. Does not include items specified under the Assistive Technology service

If an ICO is considering use of a personal position change alarm as an intervention in an enrollee's fall prevention strategy the use must be based on the assessment of the enrollee and monitored for efficacy (both beneficial and detrimental) on an ongoing basis. The alarm must be evaluated and assessed individually for each enrollee to determine if the alarm has unintended consequences such as decreased mobility, sleep disturbances, incontinence, decreased freedom of movement, or infringement of dignity. The use of an alarm as part of the IICSP cannot be restrictive in nature and does not eliminate the need for adequate supervision, nor does it replace individualized, person-centered care planning.

u. **T2028**, Specialized supply, NOS

i. Items in this category include specialized supplies that the Medicaid state plan does not cover.

ii. This may include items that do not meet the "medically necessary" standard for state plan coverage, or quantities above state plan coverage.

iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.

iv. Standardized remarks are available.

v. **T2029**, Specialized medical equipment, NOS

i. Items in this category include specialized equipment that the Medicaid state plan does not cover or does not cover for adults.

ii. This may include items that do not meet the "medically necessary" standard for state plan coverage.

iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.

iv. Standardized remarks are available.

18.2 Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS)	
Description	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.
HCPCS Codes	**S5160**, Emergency response system; installation and testing **S5161**, Emergency response system; service fee, per month (excludes installation and testing)
Units	S5160, per installation S5161, per month
Service Delivery Options	☑ Traditional ☐ Self-Determination

18.2.1. Minimum Standards for Service Delivery

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 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.
3. The provider must assure at least monthly testing of each PERS unit to assure continued functioning.
4. PERS does not cover monthly telephone charges associated with phone service.
5. 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. The ICO 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.

6. 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.
7. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
8. 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.
9. The provider will furnish each responder with written instructions and provide training, as appropriate.
10. For provider qualifications, refer to Appendix 7.

18.3 Respite (provided at the enrollee's home or in the home of another person)

Respite (provided at the enrollee's home or in the home of another person)	
Description	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.
HCPCS Codes	**S5150**, Unskilled respite care, not hospice, per 15 minutes
Units	S5150 = 15 minutes
Service Delivery Options	☑ Traditional ☐ Self-Determination

18.3.1. Minimum Standards for Traditional Service Delivery

1. 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 <u>unpaid</u> care.**
2. **Only the <u>unpaid</u> care may be replaced with respite.**
3. The ICO must establish and follow written eligibility criteria for in-home respite that include, at a minimum:
    a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
    b. Enrollees have difficulty performing or are unable to perform ADLs without assistance.
4. Respite services include:
    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.

5. The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing individual describing the respite support services the enrollee needs. Each ICO or direct service provider shall ensure the skills and training of the respite provider assigned are appropriate for the condition and needs of the enrollee.
6. With the assistance of the enrollee and/or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.
7. Each direct service provider shall establish written procedures that govern the medication assistance given by staff to enrollees. 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 the conditions under which 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. The enrollee shall maintain all medications in their original, labeled containers.
    c. Instructions for entering medication information in enrollee files.
    d. A clear statement of the enrollee's and his or her family's responsibility 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.
8. Each direct service provider shall employ a professionally qualified supervisor that is available to staff during their shift while providing respite care.
9. Members of an enrollee's family who are not the enrollee's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an enrollee by that person's spouse.
10. Family members who provide respite services must meet the same standards as providers who are unrelated to the enrollee.
11. 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.

12. Respite is limited to 14 overnight stays or 24-hour periods per 365 days (336 hours per 365 days). The ICO may provide more Respite services as a flexible benefit or on a case by case basis. The ICO has flexibility to work within the 336 hours in such a way that best meets the enrollee's needs.
13. Respite services cannot be scheduled on a daily basis
14. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers
15. The costs of room and board are not included.
16. For enrollees receiving respite services through the PIHP, they must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.
17. For provider qualifications, refer to Appendix 7.

18.4 Respite (provided outside of the home)

Respite (provided outside of the home)	
Description	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 services may be provided in a licensed Adult Foster Care, Home for the Aged facility, or nursing home. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home, licensed Home for the Aged, or nursing home.
HCPCS Codes	**H0045**, Respite services not in the home, per diem
Units	H0045 = per day
Service Delivery Options	☑ Traditional ☐ Self-Determination

18.4.1. Minimum Standards for Traditional Service Delivery

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 ICO must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:

    a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
    b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.

3. Respite services include:

    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.

4. The direct service provider must obtain a copy of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing individual describing the respite care support services the enrollee needs.
5. With the assistance of the enrollee and/or enrollee's caregiver, the ICO and/or direct service provider shall determine an emergency notification and contingency plan for each enrollee for emergencies.
6. Each direct service provider shall establish written procedures to govern assistance given by staff to enrollees who need help with medications. 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 in taking either 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. The enrollee shall maintain all medications in their original, labeled containers.
    c. Instructions for entering medication information in enrollee files.
    d. A clear statement of the enrollee's and his or her family's responsibility regarding medications taken by the enrollee while at the facility and the provision for informing the enrollee and his or her family of the program's procedures and responsibilities regarding assisted self-administration of

medications.

7. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.
8. Respite is limited to 14 overnight stays or 24-hour periods per 365 days (336 hours per 365 days). The ICO may provide more Respite services as a flexible benefit or on a case by case basis. The ICO has flexibility to work within the 336 hours in such a way that best meets the enrollee's needs.
9. MDHHS does not intend Respite services to be furnished on a continual basis. Respite services should be utilized for the sole purpose of providing temporary, intermittent relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically- necessary services on a regular basis, the ICO should work with the enrollee and caregiver to develop a plan of service that includes other waiver services, as appropriate.
10. Respite services cannot be continually scheduled on a daily basis. Out of home respite may be scheduled for several days in a row, depending upon the needs of the enrollee and the enrollee's caregivers.
11. For enrollees receiving respite services through the PIHP, they must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.
12. For provider qualifications, refer to Appendix 7.

18.5 Community Transition Services (State Plan Service effective 10/01/18)

Community Transition Services	
Description	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.
HCPCS Codes	**T1028** Assessment of home, physical and family environment, to determine suitability to meet enrollee's medical needs **T2038** Community Transition, waiver; per service
Units	T1028, per encounter T2038, per service
Service Delivery Options	☑ Traditional ☐ Self-Determination

18.5.1. Minimum Standards for Service Delivery

1. Allowable transition costs include the following:
    i. Housing or security deposits; a one-time expense to secure housing or obtain a lease;
    ii. Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television and internet are excluded).
    iii. Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
    iv. Cleaning: A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.
    v. Coordination and support services: To facilitate transitioning of enrollee to a community setting.
    vi. Other services deemed necessary and documented within the enrollee's plan of service to accomplish the transition into a community setting. Excludes ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes.
2. Excludes hotel costs or other room and board charges.

3. **There must be an agreement with the landlord for a rental property that the security deposit must be returned to the entity that paid it initially. For example, if the ICO paid the security deposit, the agreement should state that the landlord should repay the security deposit directly to the ICO when the enrollee moves. If the enrollee can afford the security deposit and pays for it initially, the security deposit should be returned directly to him/her.**
4. The timeframes associated with this service may be extended in unique circumstances that require additional support and coordination efforts.
5. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
6. Person-centered planning must be used throughout the entire community transition process.
7. Providers may bill for assessments of potential residential settings using HCPCS code T1028. The ICO may use this code more than once per transition, **but the federal government limits use to one unit per day.** This service includes supports and coordination provided by a knowledgeable health professional (i.e. physical therapist or occupational therapist) during the assessment of the potential residential setting. HCPCS code T1028 is a per encounter code. This health professional cannot be a paid staff member of the ICO. When ICO staff provides the assessment of the home, this is considered a regular care coordination function.
8. When an ICO authorizes more than one potential home assessment for an enrollee per transition, the units shall equal no more than one per day, regardless of the number of assessments completed. The cost shall equal the total cost of all assessments.
9. The ICO shall report all other transition services using HCPCS code T2038 with the appropriate standard remark for each transition service. A listing of standard remarks is provided at the end of this document. When a transitioning enrollee requires a transition service that does not have an appropriate standard remark, the ICO shall contact MDHHS for assistance. The ICO shall report encounters under HCPCS code T2038 that

are provided after the first date of waiver enrollment using the date of service delivery as the billed date of service.

10. When an ICO anticipates that a nursing facility resident receiving CTS will require MI Health Link HCBS waiver services in the community, the ICO shall make necessary arrangements for that person. CMS requires the ICO to authorize all CTS to persons expected to enroll in the waiver upon transition. Therefore, an ICO or entity under contract with an ICO shall perform all transition activity for a nursing facility resident expected to enroll in the waiver upon transition.
11. Using a person-centered planning process, the ICO must develop a transition plan that includes all enrollee goals and is based on individual needs. This transition plan becomes part of the enrollee's case record maintained by the ICO and must minimally include the following elements:
    a. Nursing facility resident name.
    b. Nursing facility resident identifying information including Social Security Number and Medicaid ID number.
    c. Name and address of nursing facility in which the resident resides.
    d. Date of initial contact.
    e. Estimated date of transition to the community and the waiver.
    f. Needed or anticipated Community Transition Services.
    g. Enrollee goals and expected outcomes of community transition.
    h. Dated signature of enrollee or legal representative.
    i. Dated signature of care coordinator assisting with the development of the plan.
12. For persons expected to enroll in the MI Health Link HCBS waiver, when a transitioning enrollee requires a home modification (ramp, widened doorways, etc.) before the transition can take place, the ICO shall authorize only those modifications immediately necessary for community transition as CTS. The ICO shall authorize all other needed modifications as Environmental Modifications services or Chore services through the waiver, as appropriate.
13. The ICO shall begin CTS no more than six months before the expected discharge from the nursing facility.
14. For transitions that occur after 9/30/2018, the transition payment

will be included in the rates, and there is not a minimum length of stay in the nursing facility to qualify for this service.

15. For provider qualifications, refer to Appendix 7.

19. MI Health Link HCBS Waiver

19.1 Eligibility

The individual must:

- be enrolled in the MI Health Link program,
- meet nursing facility level of care as determined by Michigan's Medicaid Nursing Facility Level of Care Determination tool,
- have a need for one or more of the 13 services listed below:
  i. Adaptive Medical Equipment and Supplies
  ii. Adult Day Program
  iii. Assistive Technology
  iv. Chore Services
  v. Environmental Modifications
  vi. Expanded Community Living Supports
  vii. Fiscal Intermediary
  viii. Home Delivered Meals
  ix. Non-Medical Transportation
  x. Personal Emergency Response System
  xi. Preventive Nursing Services
  xii. Private Duty Nursing
  xiii. Respite

Enrollees must receive at least one waiver service each month to remain enrolled in the MI Health Link HCBS Waiver. If the individual no longer receives at least one waiver service per month (in addition to Fiscal Intermediary services, as applicable), the ICO must immediately disenroll the individual in CHAMPS as soon as the ICO is aware the individual no longer requires waiver services or has not received waiver services. Note: When a waiver enrollee is admitted to a nursing facility, the admission entered by the facility will automatically end date the waiver enrollment. For the first 60 days of nursing facility stay, the ICO can continue to provide the following waiver services if necessary:

- Chore Services (e.g. snow removal, lawncare)
- Fiscal Intermediary (when the enrollee participates in a self-determination arrangement for chore services.)

If the ICO continues to provide waiver services during the long term care facility stay, they must note this on the new waiver enrollment upon discharge. When an enrollee is discharging from a long term care facility, the ICO may enter a new waiver enrollment in CHAMPS on the day of facility discharge.

If an individual is enrolled in the HCBS Waiver and is admitted to a hospital for one or more full calendar months, unless there is at least one day of waiver services during the month, the ICO must disenroll the member from the waiver. A Disenrollment entered by an ICO can only be dated the last date of the current month or the last date of the previous month.

Examples for disenrolling related to hospitalization:

1) An individual is in the community receiving waiver services on 5/1/2017, goes into the hospital on 5/2/2017. Discharge occurs on 5/31/2017, and the individual receives waiver services again on 6/1/2017. The ICO **does not** need to disenroll from the waiver because there is at least one day of waiver services received during the calendar month.

2) An individual is in the community receiving waiver services through 5/15/2017, goes into the hospital on 5/16/2017. Discharge occurs on 6/15/2017, and the individual receives waiver services again on 6/16/2017. The ICO **does not** need to disenroll from the waiver because there is at least one day of waiver services received during the calendar months of May and June.

3) An individual is in the community receiving waiver services on 5/1/2022, goes into hospital on 5/2/2022. Discharge occurs on 7/31/2022, and the individual receives waiver services again on 8/1/2022. The ICO **does** need to disenroll the individual. If the individual has not discharged from the hospital by 6/30/2022, The ICO must enter the disenrollment effective 5/31/2022. **This must be completed by 6/30/2022.** The ICO will need to re-enroll the individual in the waiver upon discharge from the hospital 8/1/2022 if indicated. **This enrollment can be entered effective 8/1/2022 by 8/31/2022.**

Note: If an enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines, care coordination contacts and activities may be made via HIPAA compliant virtual method (video only) in lieu of in person during the quarantine or isolation period only if the enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines. If assessments are completed via virtual method (video only) during quarantine/isolation, any sections of the assessment(s) related to physical

function that normally require in person observation by the assessor must be reviewed at the next in person visit to ensure accuracy.

19.2 Waiver Enrollees Move out of State

When an ICO enrollee that is on the waiver moves out of state permanently the ICO may discontinue waiver services when the enrollee no longer resides in the service area. Thus, the ICO does not need to cover waiver services through the date of disenrollment (the last day of the month) when the enrollee moves out of state. The ICO, at their discretion, may help the waiver enrollee access resources in other states to aid in the transition to the new service area.

The ICO does remain responsible for all other (non- HCBS waiver) covered MMP services until an enrollee's date of disenrollment after a move out of state. ICOs may utilize a single case agreement, as defined by the Three Way Contract, to ensure a member's access to non-HCBS waiver services when the member has moved permanently out of state or out of the ICOs service area until the enrollee's date of disenrollment.

Refer to MOS section 21.5 for submitting disenrollment through CHAMPS and the Service Request Process Guide for reporting out of service area.

19.3 Quality Assurance Review Findings and Remediation

MDHHS uses a quality assurance review process to monitor ICO compliance with the MI Health Link 1915(c) waiver requirements. 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.

19.4 Services

The ICO and direct service providers must adhere to the definition and operating standards to be eligible to receive payment of waiver expenses.

The ICO should authorize waiver services in accordance with the waiver requirements/service definition. Where present, applicable limits are indicated within the waiver application for each waiver service.

Medicaid funds may not be used to pay for fines, fees or taxes levied on an individual's property for purposes of blight cleanup or otherwise. ICOs are permitted to cover these payments with their own money if these issues present a barrier to providing HCBS Waiver services.

19.5 Adaptive Medical Equipment and Supplies

Adaptive Medical Equipment and Supplies	
Description	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 through the ICO 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.
HCPCS Codes	Please see the list indicated below.
Units	Per item, unless otherwise specified.
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.5.1. Minimum Standards for Service Delivery

1. 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.
2. Items must meet applicable standards of manufacture, design, and installation.
3. There must be documentation on the IICSP or case record that the best value in warranty coverage was obtained at the time of purchase.
4. Items must be of direct medical or remedial benefit to the enrollee, and this benefit must be documented in the IICSP.
5. 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).
6. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate. This

must be verified at the beginning of service delivery and annually thereafter.

7. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
8. Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the enrollee's physician.
9. The ICO shall not authorize waiver payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not authorized by the FDA.
10. Some examples (not an exhaustive list) of covered items would be non-standard shower chairs/benches (standard shower chair, covered by state plan effective 1/1/2024), lift chairs, 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.
11. For provider qualifications, refer to Appendix 7.
12. The following HCPCS codes are approved for use under the Adaptive Medical Equipment and Supplies service:
    a. **A4931**, Oral Thermometer, Reusable, any type, each
    b. **A4932**, Rectal Thermometer, Reusable, any type, each
    c. **A9300**, Exercise Equipment
    d. **B4100**, Food thickener, administered orally, per ounce
    e. **B4150/BO**, Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit
        i. The ICO must use the BO modifier to indicate oral administration. The state plan covers formulae for tube feeding.
        ii. This product may be in any form, liquid, solid, powder,

bar, etc.

iii. For cans of nutritional supplement, one can equals one unit.

iv. For bars of nutritional supplement, one bar equals one unit.

f. **E0160**, Sitz type bath or equipment, portable, used with or without commode

g. **E0161**, Sitz type bath or equipment, portable, used with or without commode, with faucet attachment

h. **E0210**, Electric heat pad, standard

i. **E0215**, Electric heat pad, moist

j. **E0242**, Bathtub rail, floor base

k. **E0315**, Bed accessory; board, table, or support device, any type

l. **E0627**, Seat lift mechanism incorporated into a combination lift chair mechanism

m. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric

n. **E0745** Neuromuscular stimulator, electronic shock unit

o. **E1300** Whirlpool, portable (overtub type)

p. **E1310** Whirlpool, non-portable (built-in type)

q. **E1639**, Scale, each

r. **S5162**, Emergency response system; purchase only

s. **S5199**, Personal care item, NOS, each

i. Use this code for items that the enrollee uses to perform ADLs or IADLs, or that assist the enrollee in the performance of ADLs or IADLs.

ii. This category shall exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.

iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.

iv. Standardized remarks are available.

t. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in “remarks”

i. Items in this category have a therapeutic use for the enrollee.

ii. The ICO must include a description of this item in the appropriate loop for approval of a claim.

iii. Standardized remarks are available.

iv. Does not include items specified under the Assistive Technology service.

If an ICO is considering use of a personal position change alarm as an intervention in an enrollee’s fall prevention strategy the use must be based on assessment of the enrollee and monitored for efficacy (both beneficial and detrimental) on an ongoing basis. The

alarm must be evaluated and assessed individually for each enrollee to determine if the alarm has unintended consequences such as decreased mobility, sleep disturbances, incontinence, decreased freedom of movement, or infringement of dignity. The use of an alarm as part of the IICSP cannot be restrictive in nature and does not eliminate the need for adequate supervision, nor does it replace individualized, person-centered care planning.

u. **T2028**, Specialized supply, NOS
    i. Items in this category include specialized supplies that the Medicaid state plan does not cover.
    ii. This may include items that do not meet the "medically necessary" standard for state plan coverage, or quantities above state plan coverage.
    iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.

v. **T2029**, Specialized medical equipment, NOS
    i. Items in this category include specialized equipment that the Medicaid state plan does not cover or does not cover for adults.
    ii. This may include items that do not meet the "medically necessary" standard for state plan coverage.
    iii. The ICO must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.

19.6 Adult Day Program

Adult Day Program	
Description	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 IICSP, 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 ICO will pay for the transportation to and from the Adult Day Program center separately.
HCPCS Codes	S5100, Day care services, adult, per 15 minutes S5101, Day care services, adult, per half day S5102, Day care services, adult, per diem
Units	S5100 = 15 minutes S5101 = half day, as defined by ICO and provider S5102 = per diem
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.6.1. Minimum Standards for Service Delivery

1. Enrollees cannot receive personal care services 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. Personal care services and Expanded Community Living Supports may be used in conjunction with Adult Day Program services but cannot be provided at the exact same time unless the specific component of the service includes laundry, housecleaning, etc., that does not require the enrollee to be present.

2. Adult Day Program should only be authorized if the enrollee meets at least one of the following criteria:
    a. Requires regular supervision to live in his or her own home or the home of a relative
    b. If he or she has a caregiver, the enrollee must require a substitute caregiver while his or her regular caregiver is unavailable
    c. Has difficulty or is unable to perform ADLs without assistance
    d. Capable of leaving his or her residence with assistance to receive services
    e. 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

A referral from an ICO for a waiver enrollee shall replace any screening or assessment activities performed for other Adult Day Program enrollees at the setting. The direct adult day program service provider shall accept copies of the ICO's assessments and Individual Integrated Care and Supports Plan (IICSP) to eliminate duplicate assessment and service planning activities.

3. Each program shall provide directly or arrange for the provision of the following services.
    a. Transportation
    b. Personal Care
    c. Nutrition: one hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home delivered meals service standard. Enrollees in attendance from eight to fourteen hours per day shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where feasible and appropriate. Such modifications shall take into consideration enrollee choice, health, religious and ethnic diet preferences
    d. Recreation: consisting of planned activities suited to the needs of the enrollee and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction

If the program arranges for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place. For MI Health Link HCBS enrollees, the ICO shall provide care coordination.

4. Each program shall maintain comprehensive and complete files that include, at a minimum:
    a. Details of the enrollee's referral to the adult day program.
    b. Intake records.
    c. Assessment of individual need or copy of assessment (and reassessments from referring program.
    d. IICSP and any other service plan developed by the program site.
    e. Listing of enrollee contacts and attendance.
    f. Progress notes in response to observations (at least monthly).
    g. Notation of all medications taken on premises, including:
        i. the medication;
        ii. the dosage;
        iii. the date and time of administration;
        iv. the initials of the staff person assisting with administration; and
        v. comments
    h. Notation of basic and optional services provided to the enrollee.
    i. Notation of any and all release of information about the enrollee.
    j. Signed release of information form.

    Each program shall keep all enrollee files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.
5. 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 participants. 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.
6. Each program shall establish written procedures (reviewed and approved by a consulting Pharmacist, Physician, or Registered Nurse) that govern the assistance given by staff to enrollees taking their own medications while participating in the

program. The policies and procedures must minimally address:

a. Written consent from the enrollee or enrollee's representative, to assist in taking medications.
b. Verification of the enrollee's medication regiment, including the prescriptions and dosages.
c. The training and authority of staff to assist enrollees with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place.
d. Procedures for medication set up.
e. Secure storage of medications belonging to and brought in by enrollees. Medications must be returned to the enrollee.
f. Instructions for entering medication information in enrollee files, including times and frequency of assistance.

7. Program staff shall have basic first-aid training and any other training as required by MDHHS and the ICO.
8. 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. The Secretary of State shall appropriately license all drivers and vehicles and 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 program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

9. Each adult 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 and/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.
10. 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.

11. Each adult day program center shall document that it is in compliance with:
    a. Barrier-free design specification of Michigan and local building codes.
    b. Fire safety standards.
    c. Applicable Michigan and local public health codes.
12. HCPCS codes S5101 and S5102 are limited to one unit per day.
13. For provider qualifications, refer to Appendix 7.
14. **Adult Day Program settings must be compliant with the HCBS Final Rule. Refer to the "HCBS Final Rule Requirements for Residential and Non-Residential Settings" section within this document.**

19.7 Assistive Technology

Assistive Technology	
Description	Assistive technology is defined as: An item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of enrollees. Assistive technology service means a service that directly assists an enrollee in the selection, acquisition, or use of an assistive technology device. 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.
HCPCS Codes	**T1999,** Misc. Therapeutic items & supplies, retail purchase, any type. Some specific items are: - 0204, Adaptive or specialized communication device - 0206, Assistive dialing device - 0208, Adaptive door opener - 0209, Specialized alarm or intercom - 0218, Other adaptive or assistive device **V5268**, Assistive listening device, telephone amplifier, any type **V5269**, Assistive listening device, alerting, any type **V5270**, Assistive listening device, television amplifier, any type Other assistive technology devices not included under Adaptive Medical Equipment and Supplies
Units	Per item unless otherwise specified
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.7.1. Minimum Standards for Service Delivery

1. Assistive technology includes:
    - The evaluation of the assistive technology needs of an enrollee, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the enrollee in the customary environment of the enrollee. Evaluation should include a description of the enrollees needs, a description of their abilities without AT, a description of how the assistive technology will meet their needs and a list of all assistive technology and services that

would be most effective to meet the needs of the enrollee.

- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for enrollees; This does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- Training or technical assistance for the enrollee, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the enrollee; and
- Examples include, but are not limited to, 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. Items like cell phones, internet service, full-home wiring systems would be excluded from this benefit.

2. It must be documented in the IICSP that the item is the most cost-effective alternative to meeting the enrollee's needs.
3. Items must meet applicable standards of manufacture, design, and installation.
4. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.
5. Items must be of direct medical or physical benefit to the enrollee.
6. **$5000 yearly (waiver year) maximum for all other assistive technology devices.**
7. Each direct service provider must enroll in Medicare and Medicaid as a DMEPOS provider, pharmacy, etc., as appropriate. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.
8. The ICO may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the ICO must assure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific enrollee who received the purchased item.
9. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract

between MDHHS and the ICO and/or the Three-Way Contract. Contracted/subcontracted providers must have any appropriate state licensure or certification required to complete or provide the service or item. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

10. Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the enrollee's physician.
11. The enrollee's privacy must be protected while utilizing assistive technology. Video recording is not allowed. The ICO should support individuals who need assistance with using the technology required for virtual video contacts through education and training. Consent and education for virtual visits (during quarantine/isolation) may be obtained at any point ahead of virtual technology being utilized. ICO Care Coordinator or LTSS Supports Coordinator should identify and discuss potential risks with the enrollee during the assessment and reassessments i.e. assistive technology related to privacy for enrollees.
12. For provider qualifications, refer to Appendix 7.

19.8 Chore Services

Chore Services	
Description	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, and pest control. May include materials and disposable supplies used to complete chore tasks. Chore services are allowed only in cases when neither the enrollee nor anyone else in the household is able to provide and/or capable of financially paying for chore services, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. If another person lives in the same household as the enrollee and is capable of providing chore services, that person is responsible for chore tasks even if he or she does not want to provide them. Household members who do not have time to provide chore services due to work, schooling, or caregiver responsibilities are not considered capable of providing chore services. 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.
HCPCS Codes	**S5120**, Chore Services, per 15 minutes **S5121**, Chore Services, per diem
Units	S5120 = 15 minutes S5121 = Per diem
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.8.1. Minimum Standards for Traditional Service Delivery

1. The ICO may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver enrollees.
2. Each ICO must develop working relationships service providers, as available, in their program area to ensure effective coordination of efforts.
3. Pest control suppliers must be properly licensed.
4. For provider qualifications, refer to Appendix 7.
5. Providers must be able to communicate effectively both orally and in writing. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

19.8.2. Minimum Standards for Self-Determined Service Delivery

1. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the IICSP.
2. The ICO must deem the chosen provider capable of performing the required tasks.

19.9 Environmental Modifications

Environmental Modifications	
Description	Physical adaptations to the primary residence or the enrollee's family residence if applicable, required by the enrollee's IICSP 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.
HCPCS Codes	**S5165**, Home modifications, per service
Units	One modification or adaptation
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.9.1. Minimum Standards for Service Delivery

1. Such adaptations include the installation of ramps and grab bars (suction cup grab bars are prohibited), 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 competed 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.
    - Note: If installation of a piece of equipment requires being screwed into a wall (e.g., E0241/E0243), the ICO can use S5165 with standard remark '5005: Equipment Installation Charge' to provide waiver coverage for the installation.
2. Porch/patio/stair railings may be provided as long as it is directly related to enhancement of the enrollee's mobility.
3. Patios, decks, stairs or walkways may be installed or restructured if directly related to enhancement of the enrollee's mobility.
4. Environmental modifications such as ramps, etc., are **NOT** limited to individuals in wheelchairs. Ramps may be provided for anyone who has

mobility challenges with trouble entering and exiting the residence. For example, an enrollee who does walk but has difficulty climbing stairs to get into and out of the home may benefit from a ramp.

5. 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 must use Medicaid state plan, Medicare, or other available payers first.
6. 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.
    - Care Coordinators must document any attempts they make to secure alternate funding (discussion with family on resources, internet research, phone calls, emails, etc.) in their case notes.
    - A signed and dated statement by the care coordinator that they have made diligent attempts and were unable to find and/or secure alternative payment sources will satisfy this requirement for the Environmental Modification Service.
    - If, in the Care Coordinator's assessment, the process to secure alternate funding sources (once initiated) will create a barrier to timely access to needed services that will have a negative impact on the beneficiary's health and welfare, the care coordinator should document this assessment and may proceed with implementing the environmental modification.
7. This service shall not be used for upgrades to the home or for additions to homes (adding square footage, etc.). Modifications/adaptations shall only be used to modify existing spaces or structures. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
8. The modification/adaptation must be for a primary residence but may include additional residences subject to prior authorization by the ICO.

Physical adaptations to the primary residence or the enrollee's family residence if applicable, 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. Examples of additional residences might be a family member's cottage or the enrollee's second home or cottage so the enrollee can go there and be with family.

9. The ICO may use MI Health Link 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.
10. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as part of the cost of the service.
11. 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.
12. 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 enrollee, and the ICO must specify any requirements for restoration of the property to its original condition if the occupant moves. If the ICO is experiencing a scenario in which the landlord is refusing to allow reasonable modifications for individuals with disabilities to be completed on their properties the landlord may have an obligation to allow the reasonable accommodation. Please refer to the federal Fair Housing Act for details Civil Rights Division | The Fair Housing Act
13. Repairs, modifications, or adaptations shall not be performed on a condemned structure or a home in the foreclosure process. A home is considered in the foreclosure process once the Sheriff's sale date is scheduled and published in the county newspaper.
14. The modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements.
15. Excluded are those adaptations or improvements to the home that:
    a. Are of general utility;
    b. Are considered to be standard housing obligations of the enrollee or homeowner; and (See examples in specific exclusions listed below of modifications that would be general utility and a standard obligation of the enrollee.

c. Are not of direct medical or remedial benefit to the enrollee. For example, a kitchen modification required for the enrollee to prepare his or her own meals is a modification with a direct remedial benefit. Whereas a general kitchen remodel is of general utility and a standard housing obligation of the enrollee.

16. 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 unless directly related to the adaptations/modifications being made due to a medical or remedial benefit.
17. 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.
18. 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.
19. Environmental adaptations 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.
20. The existing structure must have the capability to accept and support the proposed changes.
21. The ICO shall 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, MI Health Link 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 ICO may fund the difference between the standard fixture and the modification required to accommodate the enrollee's need.
22. A ramp or lift will be covered for only one exterior door or other entrance unless otherwise approved by MDHHS.

23. Contracted providers such as licensed building contractors, must have appropriate certification or licensure under Michigan regulations and law such as MCL 339.601(1), MCL 339.601.2401, or MCL 339.601.2403(3).
24. Verification of certification, licensure, or other provider qualifications must be done prior to execution of the contract related to the modification project to be done.
25. 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. It 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.
26. For provider qualifications, refer to Appendix 7.

19.10 Expanded Community Living Supports

Expanded Community Living Supports	
Description	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, money management, 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 includes social/community participation, relationship maintenance, and attendance at medical appointments.
HCPCS Codes	**H2015**, Comprehensive community support services, per 15 minutes
Units	H2015 = 15 minutes
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.10.1. Minimum Standards for Traditional Service Delivery

1. Expanded Community Living Supports (ECLS) include:
    a. **To qualify for this service, the enrollee MUST have a need for prompting, cueing, supervision for at least one ADL (eating, bathing, dressing, toileting, personal hygiene, etc.).**
    b. **If and only if the enrollee qualifies for ECLS based on ADL needs,** he or she may also receive hands-on assistance or prompting, cueing, supervision for at least one IADL (laundry, meal preparation, transportation, money management, help with medication, shopping, attending medical appointments, and other household tasks). Also covered are

assistance, support, and/or guidance with such activities as:

i. Money management
ii. Non-medical care (not requiring nursing or physician intervention)
iii. Social participation, relationship maintenance, and building community connections to reduce personal isolation
iv. Transportation (excluding to and from medical appointments) from the enrollee's residence to community activities, among community activities, and from the community activities back to the enrollee's residence
v. Participation in regular community activities incidental to meeting the enrollee's community living preferences
vi. Attendance at medical appointments
vii. Acquiring or procuring goods and services necessary for home and community living

c. Reminding, cueing, observing, and/or monitoring of medication administration
d. Staff assistance with preserving the health and safety of the enrollee in order that he/she may reside and be supported in the most integrated independent community setting.
e. Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
f. Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the enrollee as identified in the enrollee's IICSP.
g. Observing and reporting to the care coordinator any changes in the enrollee's condition and the home environment.
h. If the enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines, ECLS services that only require verbal cueing may be provided via HIPAA compliant virtual method (audio and video only; cannot be only audio) in lieu of in person during the quarantine or isolation period only. Approval of remote support must be reflected on the individual integrated care and support plan. If virtual method is utilized, the enrollee's privacy must be protected during virtual visits. Video recording is not allowed. The ICO should support individuals who need

assistance with using the technology required for virtual video contacts through education and training. Written or electronic consent must be obtained from the enrollee for use of the virtual option. Consent and education for virtual visits (during quarantine/isolation) may be obtained at any point ahead of the virtual method being utilized.

2. Individual providers who are chosen by the enrollee must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

    a. 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 related to this service, the provider must possess a valid Michigan driver's license.
    b. Individuals providing ECLS 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.
    c. Previous relevant experience and training to meet MDHHS operating standards. Refer to the ICO contract for more details.
    d. Must be deemed capable of performing the required tasks by ICO.

3. Home Care agency providers must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

    a. 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-borne pathogens, and be in good standing with the law as validated by a criminal history review.
    b. A registered nurse licensed to practice nursing in the State shall furnish supervision of ECLS providers. At the State's discretion, other qualified individuals may supervise ECLS providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing ECLS services.
    c. 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 ECLS services complete a certified nursing assistance training course.

d. ECLS providers may prompt, cue, or supervise the enrollee to 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.

e. Individuals providing ECLS services must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

4. When the ECLS services provided to the enrollee include transportation, the following standards apply:
   a. The ICO may not use MI Health Link funds to purchase or lease vehicles for providing transportation services to waiver enrollees.
   b. The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MI Health Link funds. The provider must cover all vehicles used with liability insurance.
   c. All paid drivers for transportation providers supported entirely or in part by MI Health Link 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.
   d. The provider shall train all paid drivers for transportation programs supported entirely or in part by MI Health Link funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
   e. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
   f. Additionally, transportation on behalf of the enrollee during the quarantine or isolation period to allow others to obtain items required for the enrollee is also acceptable. Plans

may use this service to authorize MI Health Link HCBS funds to reimburse individuals (ECLS providers) to run errands for enrollees when the enrollee does not accompany the driver of the vehicle during only an applicable quarantine or isolation period. The purpose of expanding the ECLS service is for the enrollee to gain access to the community as needed during these temporary periods when the enrollee is required to isolate due to their condition. For example, while the enrollee is isolated, the provider may complete a task such as shopping that they would normally accompany the enrollee to do when the enrollee is not required to be isolated.

5. Each direct service provider who chooses to allow staff to assist enrollees with self-medication shall establish written procedures that govern the assistance given by staff. These procedures shall be reviewed by a consulting pharmacist, physician, or RN 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. The enrollee shall maintain all medications in their original, labeled containers.
    c. Instructions for entering medication information in enrollee files.
    d. A clear statement of the enrollee's and his/her family's responsibility regarding medications taken by the enrollee and the provision for informing the enrollee and his/her family of the provider's procedures and responsibilities regarding assisted self-administration of medications.
6. ECLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:
    a. 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.
    b. A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
    c. A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
    d. A provider shall review the administration of a psychotropic medication periodically as set forth in the

enrollee's IICSP and based upon the enrollee's clinical status.

e. 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.
f. A provider shall record the administration of all medication in the enrollee's record. The ICO may do this electronically or via paper format, but the records must be readily available if requested by MDHHS.
g. 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 record.

7. ECLS cannot be provided in circumstances where they would be a duplication of services available through MI Health Link. The distinction must be apparent by unique hours and units in the approved IICSP.
8. ECLS does not include the cost associated with room and board.
9. ECLS may be furnished outside the enrollee's home.
10. 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. When transportation incidental to the provision of ECLS is included, the ICO shall not also authorize transportation as a separate waiver service for the enrollee.
11. ECLS services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere.
12. ECLS excludes nursing and skilled therapy services.
13. Members of an enrollee's family may provide ECLS to the enrollee. However, the ICO shall not directly authorize funds to pay for services furnished to an enrollee by that person's spouse or legal representative/guardian or other financially responsible person. Family members who provide this service must meet the same standards as providers who are unrelated to the enrollee. Roommates or other individuals who live with the enrollee may provide ECLS services, but payment for services must be pro-rated by one-half if the service will also benefit the person performing the service (i.e. meal preparation, laundry, housecleaning, etc.). Paid ECLS services are **only** for the benefit of the enrollee receiving the services.
14. In shared living arrangements where there is more than one person in the home receiving the service by the same caregiver, payment for services must be based on a pro-rated percentage/fraction relative to the care each person receives. When services can be clearly documented separately from other individuals in the home, payment need not be pro-

rated. 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.

15. 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. **ECLS and Personal Care Services may not both be provided for the same ADL or IADL <u>at the same time</u> during the day. For example, supervision/prompting/cueing for Bathing should not be provided at the same time as the hands-on assistance for Bathing. If hands-on assistance is needed at this time, the billing should be for Personal Care Services instead of ECLS.**
16. It is okay for ECLS and Personal Care Services to be used for the same ADL or IADL during the same day but at different times during the day. For example, the individual may need prompting/cueing/supervision in the morning and more hands-on assistance in the evening due to being more tired at the end of the day. This is an acceptable use of the services as long as they are assessed, billed and paid according to appropriate service code.
17. 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.
18. With the assistance of the enrollee and/or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.
19. For provider qualifications, refer to Appendix 7.

19.10.2. Additional Standards for Enrollees Who Reside in Licensed Settings

1. ECLS provided in a licensed setting includes only those supports and services that are in addition to, and shall not replace, usual and customary care furnished to residents in the licensed setting.
2. Documentation in the enrollee's record must clearly identify the enrollee's need for additional supports and services not covered by licensure.
3. The IICSP must clearly identify the portion of the enrollee's supports and services covered by ECLS.

19.10.3. Minimum Standards for Self-Determined Service Delivery

1. When authorizing ECLS for enrollees choosing the self-determination option, the ICO must comply with service definitions described in the Minimum Standards for Traditional Service Delivery specified above.
2. Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.
3. Providers must meet the same qualifications as those under the traditional service delivery model.
4. When the ECLS services provided to the enrollee include tasks specified in 1.a. iv, 1.b.ii, 1.c, 1.d, 1.e, 1.f, or 1.g above under Minimum Standards for Traditional Service Delivery, the individual furnishing ECLS must also be trained in cardiopulmonary resuscitation. This training may be waived when the provider is furnishing services to an enrollee who has a "Do Not Resuscitate" order.

19.11 Fiscal Intermediary

Fiscal Intermediary	
Description	Fiscal Intermediary (FI) services assist enrollees in self-determination by providing assistance to the enrollee or family member to acquire and maintain services defined in the enrollee's plan of service, manage and direct the disbursement of funds contained in the enrollee's individual budget, and choosing the staff to work with the enrollee. The enrollee utilizes funds to purchase home and community-based services authorized in the IICSP.
HCPCS Codes	**T2025**, Waiver Services, not otherwise specified.
Units	As specified in the contract between the Fiscal Intermediary and the ICO, usually a monthly or bi-weekly fee.
Service Delivery Options	☐ Traditional ☑ Self-Determination

19.11.1. Minimum Standards for Self-Determined Service Delivery

1. Fiscal Intermediary services are available only to enrollees participating in arrangements that support self-determination. Additionally, Fiscal Intermediary services may not be provided by the enrollee's family, guardian, or providers of other services for the same enrollee.
2. 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.
3. Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.
4. Each FI must demonstrate the ability to manage budgets and perform all functions of the FI including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations.
5. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.

6. Each FI will provide four basic areas of performance:
7. Function as the employer agency for enrollees directly employing workers to assure compliance with payroll tax and insurance requirements;
8. Ensure compliance with requirements related to management of public funds, the direct employment of workers by enrollees, and contracting for other authorized supports and services;
9. Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each enrollee and ICO; and
10. Offer supportive services to enable enrollees to self-determine and direct the supports and services they need.
11. The ICO and fiscal intermediary must abide by the Self-Determination Implementation Technical Advisory and any other requirements set forth by MDHHS.
12. For provider qualifications, refer to Appendix 7.

19.12 Home Delivered Meals

Home Delivered Meals	
Description	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.
HCPCS Codes	**S5170**, Home delivered meals, including preparation, per meal.
Units	One delivered meal
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.12.1. Minimum Standards for Service Delivery

1. Each ICO must have written eligibility criteria for persons receiving home delivered meals through the waiver which include, at a minimum:
   - The enrollee must be unable to obtain food or prepare complete meals.
   - The enrollee does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
   - The enrollee does not have a paid caregiver that is able and willing to prepare meals for the enrollee, with the exception of the paid caregiver warming the Home Delivered Meals for the enrollee if he or she cannot warm the meals.
   - The provider can appropriately meet the enrollee's special dietary needs and the meals available would not jeopardize the health of the enrollee.
   - The enrollee must be able to feed himself/herself.
   - The enrollee must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

2. Each home delivered meals provider shall have the capacity to provide three 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 must have meals available at least five days per week. Enrollees may select to have up to two meals per day, which means they could receive breakfast and lunch, lunch and dinner, or breakfast and dinner.
3. 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. When the ICO provides home delivered meals less than seven days per week, the ICO shall identify and/or document in the Care Bridge Record or IICSP, the alternative source of all meals that are not provided by the ICO. Please Note: ICOs are allowed to provide two home delivered meals through the c-waiver and supplement a third meal with the hands-on personal care service of 'meal preparation' when needed.
4. ICOs must offer a variety of meal options to suit the enrollee's needs and desires. For example, if an enrollee prefers to have meals that do not need to be warmed, these should be provided. Similarly, if an enrollee prefers to have frozen meals that require warming via whatever means the enrollee has available, these should be provided.
5. The program may offer liquid meals to enrollees when ordered by a physician. The regional dietitian must approve all liquid meal products used by the provider. The provider or care coordinator must provide instruction to the enrollee and/or the enrollee's caregiver and family in the proper care and handling of liquid meals. The ICO and provider must meet the following requirements when liquid meals are the sole source of nutrition:
    - Diet orders shall include enrollee weight and specify the required nutritional content of the liquid meals.
    - The care coordinator must ensure the enrollee's physician renews the diet orders every three months, and
    - The ICO and enrollee must develop the plan of care for the enrollee receiving liquid meals in consultation with the enrollee's physician. This plan must be included in the enrollee's IICSP.

6. The provider may furnish frozen meals when feasible and appropriate. When furnishing frozen meals, the following standards must be met:
    - The care coordinator must verify and maintain records (Care Bridge Record or IICSP) that indicate each enrollee receiving frozen meals has and maintains the ability to store and handle frozen meals properly.
    - The provider may only provide frozen meals in situations where it is not logistically feasible to provide the enrollee with a hot meal, with the exception of holidays, weekends, or emergencies.
    - Providers shall not furnish more than a two-week supply of frozen meals to an enrollee during one home delivery visit.
7. Each provider shall develop and have available written plans for continuing services in emergency situations such as short-term natural disasters (e.g., snow and/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.
8. The meals authorized under this service shall not constitute a full nutritional regimen.
9. Providers shall not solicit donations from waiver enrollees.
10. Dietary supplements are not covered under this service.
11. Home Delivered Meals is not intended to provide food for enrollees solely for financial reasons in which the enrollee or his or her caregivers or family cannot afford to buy food.
12. If the enrollee has an exposure or condition for which a federal, state, or local public health or gov't official(s) has released applicable quarantine or isolation guidelines, HDMs may be left at the enrollee's door in lieu of in person during the quarantine or isolation period only. Approval of door drop off must be reflected on the individual integrated care and support plan.
13. When meal delivery kits are utilized (Hello Fresh, Blue Apron, etc.), they constitute no more than the equivalent of 2 meals/day. The IICSP must reflect the need and whether the home delivery kit meets the needs of the enrollee (e.g., enrollee has a need to access to groceries or a preference for meal delivery kits and individual is capable of (or has assistance) completing the level of preparation required with the meal delivery kit meals). Enrollees have a choice of all

willing and qualified providers. The option for prepared meals through a traditional home delivered meals provider remains available.

14. If an enrollee has been receiving Meals on Wheels or home delivered meals through sources external to the ICO (i.e., grants, Older Americans Act funding, not covered by Medicaid) and wishes to continue receiving them and meets nursing facility level of care (as evidenced by the LOCD tool), the enrollee may receive the meals through the Home Delivered Meals waiver service. A MI Health Link HCBS Waiver enrollment must be submitted to CHAMPS. Criteria in #11 above still applies. The ICO must be the payer source in order for this to qualify as the HCBS waiver service.
    - The enrollee may choose to keep receiving services through the same entity and not through the ICO and HCBS Waiver. This is fine, but the ICO is not required to pay for it. If the ICO does not pay for it, this does not qualify as the Home Delivered Meals waiver service.
15. For provider qualifications, refer to Appendix 7.

19.12.2. General Requirements

1. Providers may present hot, cold, frozen or shelf-stable meals according to the following meal pattern, but also **may be customized based on the enrollee's preferences**:

Meal Requirements	Servings per meal	Notations
Bread or Bread Alternate	2 servings of bread, rice, pasta, or cereal. A starchy vegetable may replace one bread serving.	Encourage whole grains.
Vegetable	2 servings: 1 serving = ½ cup or equivalent measure	Fresh, frozen, or canned and prepared without added sodium. Focus on deep colored and dark green leafy vegetables. Cooked dried beans or peas are a good fiber source.
Fruit	1 serving: ½ cup or equivalent measure (may serve an additional fruit instead of a vegetable)	Fresh, frozen, canned, or dried. Deep colored fruits and good sources of Vitamin C are encouraged daily.

Milk or Milk Alternate	1 serving: 1 cup or equivalent measure	Encourage low-fat or skim milk, buttermilk, yogurt or cottage cheese.
Meat or Meat Alternate	1 serving: 2-3 oz. or equivalent measure	Encourage lean and low-fat meats and cheeses. Dried beans and peas are a good choice. Peanut butter, cottage cheese, tofu, and eggs also
Fats	1 serving: 1 teaspoon or equivalent measure	Select choices that are good sources of mono-and poly-unsaturated fats. Limit total fat to no more than 30% of total daily
Dessert	Optional	Choose nutrient dense desserts such as fruits, whole grain quick breads, puddings with limited fats and sugars. Limit high calorie desserts such as pies, cakes,
Sodium	No more than 1200 mg per meal average weekly total.	Select and prepare foods with less salt or sodium and use salt-free
Fiber	3 choices out of a 5 day week high fiber	Choose whole grains, fruits and vegetables

2. In addition to the meal pattern above, servings may include the following, but also may be customized based on the enrollee's preferences:

Bread or Bread Alternate

- 1 small 2 ounce muffin
- 2" cube cornbread
- 1 biscuit, 2.5" diameter
- 1 waffle, 7" diameter
- 1 slice French toast
- ½ English muffin
- 1 tortilla, 6" diameter
- 2 pancakes, 4" diameter
- ½ bagel
- 1 small sandwich bun
- ½ cup cooked cereal, grits, barley, bulgur or masa
- 4-6 crackers
- ½ large sandwich bun
- ¾ cup ready to eat cereal

- ¼ cup granola
- 2 graham cracker squares
- ½ cup bread dressing or stuffing
- ½ cup pasta, noodles, rice

A variety of enriched and/or whole grain bread products, particularly those high in fiber, are recommended.

Vegetables

- A serving of vegetable (including dried beans, peas, and lentils) is generally ½ cup cooked or raw vegetable; ¾ cup 100% vegetable juice; or, 1 cup raw leafy vegetable. For pre-packed 100% vegetable juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh or frozen vegetables are preferred. Canned vegetables are acceptable but may be high in sodium.
- Vegetables as a primary ingredient in soups, stews, casseroles or other combination dishes should total ½ cup per serving.
- Starchy vegetables, such as potatoes, sweet potatoes, corn, yams, or plantains, may replace one of the two bread servings.

Fruits

- A serving of fruit is generally a medium apple, banana, orange, or pear; ½ cup chopped, cooked, or canned fruit; or ¾ cup 100% fruit juice. For pre-packed 100% fruit juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh, frozen, or canned fruit should be preferably packed in juice, light syrup or without sugar.

Milk or Milk Alternates

- One cup low-fat, skim, whole, buttermilk, low-fat chocolate, or lactose-free milk fortified with Vitamins A and D should be used. Low fat or skim milk is recommended for the general population. Powdered dry milk (1/3 cup) or evaporated milk (1/2 cup) may be served as part of a home delivered meal.
- Milk alternates for the equivalent of one cup of milk include:
    - 1 cup yogurt
    - 1 ½ cups cottage cheese
    - 8 ounces tofu (processed with calcium salt)
    - 8 ounces calcium fortified soy milk
    - 1+½ ounces natural or 2 ounces processed cheese

Meat or Meat Alternates

- Two to three ounces of cooked meat or meat alternate should generally be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating.

- The following are equivalent to 1 ounce of meat:
  - 1 large egg
  - 1 ounce cheese (nutritionally equivalent measure of pasteurized process cheese, cheese food, cheese spread, or other cheese product). It is best to choose low-fat cheese such as mozzarella, feta, ricotta, etc.
  - ½ cup cooked dried beans, peas or lentils (separate from vegetable serving)
  - 2 tablespoons peanut butter or 1/3 cup nuts
  - ¼ cup cottage cheese
  - ½ cup or 4 ounces tofu
  - ¼ cup tempeh
- A one ounce serving or equivalent portion of meat, poultry, or fish may be served in combination with other high protein foods.
- Except to meet cultural and/or religious preferences and for emergency meals, avoid serving dried beans, peas, lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days.
- Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non-imitation product) cannot be served as meat alternates.
- To limit the sodium content of the meals, serve cured and processed meats (e.g., ham, smoked or Polish sausage, corned beef, wieners, luncheon meats, dried beef) no more than once a week.

Accompaniments

Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include: ketchup, mustard and/or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide reduced fat alternatives. Minimize use of fat in food preparation. Fats should be primarily from vegetable sources and in a liquid or soft (spreadable) form that are lower in hydrogenated fat, saturated fat, and cholesterol.

Desserts

Serving a dessert is optional. Healthier desserts generally include fruit, low-fat puddings, whole grains, low-fat products, and limited sugar items such as quick breads (banana or pumpkin bread). Fresh, frozen, or canned fruits packed in their own juice are encouraged as a dessert item in addition to the serving of fruit provided as part of the meal.

Beverages

Fluid intake should be encouraged, as dehydration is a common problem in older adults. It is a good practice to have drinking water available.

Vegetarian Meals

Vegetarian meals can be served and should follow the principle of complementary proteins, where proteins from plant sources (legumes such as cooked dried beans and peas) are combined with grains (rice, breads, pasta) at

the same meal. Vegetarian meals are a good opportunity to provide variety to menus and highlight the many ethnic food traditions found in Michigan.

Breakfast Meals

A breakfast meal may contain three fruit servings and no vegetable as an option to the required meal plan.

3. The ICO must ensure that each provider utilizes a menu development process that prioritizes healthy choices and creativity and minimally includes:
    a. Use of written, standardized recipes.
    b. Consultation with the regional dietitian during the menu development process and use of cycle menus for cost containment and/or convenience are encouraged, but not required.
    c. Provision for review and approval of all menus by the regional dietitian who must be a registered dietitian, or an individual who is dietitian-registration eligible.
    d. The provision of information on the nutrition content of menus upon request.
    e. The provision, where feasible and appropriate, of modified diet menus that considers enrollee choice, health, religious and ethnic diet preferences.
    f. A record of the menu actually served each day. The provider shall maintain this record for each year's operation.
    g. Written procedures for revising menus after approval.
4. The provider must operate according to current provisions of the Michigan Food Code. Local Health Departments establish minimum food safety standards. Each provider must keep copy of the Michigan Food Code available for reference. MDHHS encourages providers to monitor food safety alerts.
5. Each provider that operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program approved by the Michigan Department of Agriculture. MDHHS prefers but does not require a trained and certified staff member at satellite serving and packing sites.
6. The provider shall feasibly minimize the time between the end of preparation of food and home delivery to the enrollee. The provider shall prepare, hold, and serve food at safe temperatures. The provider shall develop in conjunction with the respective local Health Department acceptable documentation requirements for food safety procedures.
7. The enrollee is responsible for the safety of food after it has been served or when it has been removed from the meal site.
8. The provider must use food from commercial sources that comply

with the Michigan Food Code. Unacceptable items include: home canned or preserved foods; foods cooked or prepared in an enrollee's home kitchen; meat from any animal not killed by a licensed facility; any wild game taken by hunters; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and any un-pasteurized products (i.e., dairy, juices and honey).

9. The provider may use contributed food only when they meet the same standards of quality, sanitation, and safety as apply to food purchased from commercial sources. Acceptable contributed food include fresh fruits and vegetables, and wild game from a licensed farm processed within two hours of killing by a licensed processor.
10. Each provider shall use standardized portion control procedures to ensure that each meal served is uniform and satisfies meal pattern requirements. The provider may alter standard portions at the request of an enrollee for less than the standard serving of an item or if an enrollee refuses an item. The provider shall not serve less than standard portions to "stretch" available food to serve additional persons.
11. Each provider shall implement procedures designed to minimize waste of food (leftovers/uneaten meals).
12. Each provider shall use an adequate food cost and inventory system at each food preparation facility. The provider shall base the inventory control on the first-in/first-out (FIFO) method and conform to generally accepted accounting principles. The system shall have the ability to provide daily food costs, inventory control records, and monthly compilation of daily food costs. Each provider has the ability to calculate the component costs of each meal provided according to the following categories:

Raw Food	All costs of acquiring food to be used in the program.
Labor	Food Service Operations: all expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving, and cleaning of meal sites, equipment and kitchens; Project Manager: all expenses for salary wages for persons involved in project management.
Equipment	All expenditures for purchase and maintenance of items with a useful life of more than one year and an acquisition cost of greater than $5,000.

Supplies	All expenditures for items with a useful life of less than one year and an acquisition cost of less than $5,000.
Utilities	All expenditures for gas, electricity, water, sewer, waste disposal, etc.
Other	Expenditures for all other items that do not belong in any of the above categories (e.g., rent, insurance, fuel, etc.) to be identified and itemized.

If a provider operates more than one meal/feeding program, the provider shall accurately distribute costs among the respective meal programs. The provider shall only charge costs directly related to a specific program.

13. Each provider shall provide or arrange for monthly nutrition education appropriate to enrollees receiving home delivered meals. Topics shall include, but are not limited to, food, nutrition, wellness issues, consumerism, and health. The regional dietitian must approve all nutrition education materials and presenters.
14. MDHHS encourages each meal provider to use volunteers, as feasible, in program operations.
15. Each provider shall develop and utilize a system for documenting meals served. Obtaining daily signatures of enrollees receiving meals is the most acceptable method of documenting meals. Other acceptable methods may include maintaining a daily or weekly route sheet signed by
the driver which identifies the enrollee's name, address, and number of meals served to him or her each day.
16. Each provider shall carry product liability insurance sufficient to cover its operation.
17. The ICO shall take steps to inform enrollees about local, State, and Federal food assistance programs and assist enrollees to obtain such benefits.

19.13 Individualized Goods and Services

Individualized Goods and Services	
Description	Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through either MI Health Link waiver or the Medicaid State Plan that address an identified need in the individual plan of services (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements. The item or service would: • Decrease the need for other Medicaid services, • Promote inclusion in the community, and • Increase the participant's safety in the home environment.
HCPCS Codes	**T5999,** Individual Goods and Services
Units	Per item, unless otherwise specified
Service Delivery Options	❑ Traditional ☑ Self-Determination

19.13.1. Minimum Standards for Service Delivery

1. These goods and services are only available if the enrollee does not have the funds to purchase the item or service or the item or service is not available through another source.
2. Goods and Services are only approved by CMS for self-direction enrollees. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the individual plan of services and must be clearly linked to an assessed enrollee need in the IICSP.
3. Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board. The specific goods and services that are purchased under this coverage must be documented in the service plan.
4. Where applicable, the enrollee must use Medicaid state plan, Medicare, or other available payers first. The participant's preference

for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

19.14 Non-Medical Transportation

Non-Medical Transportation	
Description	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).
HCPCS Codes	**A0130**, Non-Emergency Transportation; Wheelchair van; per trip **S0209**, Wheelchair van, per mile **S0215**, Non-Emergency Transportation, mileage, per mile **T2003**, Non-Emergency Transportation; encounter/trip **T2004**, Non-Emergency Transportation; commercial carrier, multi-pass
Units	A0130 = per mile S0209 = per mile S0215 = per mile T2003 = per encounter or trip T2004 = per pass
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.14.1. Minimum Standards of Service Delivery

1. Whenever possible, the ICO shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. If the service is provided at no cost to the ICO, the beneficiary would not qualify for this service.
2. Direct service providers shall be a centrally organized transportation company or agency. The provider may provide transportation utilizing any of the following methods:
   a. Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:
      i. Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the enrollee.

ii. Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.

b. Public Transit: Characterized by partial or full payment of the cost for an enrollee to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.

c. Volunteer: Characterized by reimbursement of out-of-pocket expenses for individuals who transport enrollees in their private vehicles. The provider may include a passenger assistance component.

d. Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.

3. Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance.
4. MI Health Link funds may not be used to purchase or lease vehicles for providing transportation services to waiver enrollees.
5. All paid drivers for transportation providers supported entirely or in part by MI Health Link 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.
6. 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.
7. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.
8. This service must not be used to take an enrollee to the pharmacy unless that pharmacy is also a place where the enrollee is also purchasing groceries or other non-medical items/supplies in the same trip.
9. For provider qualifications, refer to Appendix 7.

19.15 Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS)	
Description	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.
HCPCS Codes	**S5160**, Emergency response system; installation and testing **S5161**, Emergency response system; service fee, per month (excludes installation and testing)
Units	S5160, per installation S5161, per month
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.15.1. Minimum Standards for Service Delivery

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 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.
3. The provider must assure at least monthly testing of each PERS unit to assure continued functioning.
4. PERS does not cover monthly telephone charges associated with phone service.
5. 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. The ICO 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.

6. 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.
7. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.
8. 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.
9. The provider will furnish each responder with written instructions and provide training, as appropriate.
10. For provider qualifications, refer to Appendix 7.

19.16 Preventive Nursing Services

Preventive Nursing Services	
Description	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 preventive 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.
HCPCS Codes	**T1002**, RN Services, up to 15 minutes **T1003**, LPN/LVN services, up to 15 minutes
Units	15 minutes
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.16.1. Minimum Standards for Traditional Service Delivery

1. When the enrollee's condition is unstable, could easily deteriorate, or when significant changes occur, the ICO covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the enrollee's condition and report findings to the enrollee's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the enrollee.
2. The care coordinator shall communicate with both the nurse providing this service and the enrollee's health care professional to assure the nursing needs of the enrollee are being addressed.
3. Enrollees must meet at least one of the following criteria to qualify for this service:
   • Be at high risk of developing skin ulcers or have a

history of resolved skin ulcers that could easily redevelop.
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
- Require professional monitoring or oversight of blood sugar levels, including enrollee-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
- Require professional assessment of the enrollee's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
- Require professional evaluation of the enrollee's success with a prescribed exercise routine to assure its effectiveness and identify the need for additional instruction or modifications when necessary.
- Require professional evaluation of the enrollee's physical status to encourage optimal functioning and discourage adverse outcomes.
- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life- threatening changes to the enrollee's physician or other health care professional.

4. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:
   - Administering prescribed medications that cannot be self-administered (as defined under Michigan Complied Law (MCL) 333.7103(1)).
   - Setting up medications according to physician orders.
   - Monitoring enrollee adherence to his or her medication regimen.
   - Applying dressings that require prescribed medications and aseptic techniques.
   - Providing refresher training to the enrollee or informal 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.

5. This service is limited to no more than two hours per visit
6. Enrollees receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services
7. All providers must be licensed in the State of Michigan as a Registered Nurse or Licensed Practical Nurse
8. This service must not duplicate other services offered under Michigan Medicaid State Plan or Medicare. These services must be exhausted first if specific service overlaps exactly with this waiver service.
9. For provider qualifications, refer to Appendix 7.

19.16.2. Minimum Standards for Self-Determined Service Delivery

When authorizing Preventive Nursing Services for enrollees choosing the self-determination option, the ICO must comply with rules described above in the service definition and Minimum Standards for Traditional Service Delivery.

19.17 Private Duty Nursing

Private Duty Nursing	
Description	(PDN) services are skilled nursing interventions provided to an enrollee aged 21 or 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.
HCPCS Codes	**T1000**, Private duty/independent nursing service(s); Licensed, up to 15 minutes. * *Use TD modifier to indicate an RN, and TE modifier to indicate an LPN
Units	Up to 15 minutes
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.17.1. Medical Criteria

1. 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 below). Regardless of whether the enrollee meets Medical Criteria I or II, the enrollee must also meet Medical Criteria III.
    a. Medical Criteria I – The enrollee is dependent daily on technology based medical equipment to sustain life. "Dependent daily on

technology-based medical equipment" means:

i. Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
ii. Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
iii. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
iv. Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
v. 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 enrollees aged 21 or 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.

b. 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:
   i. "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.
   ii. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
   iii. "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.

iv. "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 enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

v. "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.

vi. "Substantiated" means documented in the clinical or medical record, including the nursing notes.

c. 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:

i. "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.

ii. "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:

2. 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;
3. 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;
4. Deep oral (past the tonsils) or tracheostomy suctioning;
5. 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);
6. Nasogastric tube feedings or medications when removal and insertion of the

nasogastric tube is required, associated with complex medical problems or medical fragility;

7. Total parenteral nutrition delivered via a central line and care of the central line;
8. 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 aged 21 or 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;
9. 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.

19.17.2. Minimum Standards for Traditional Service Delivery

1. All nurses providing Private Duty Nursing (PDN) to waiver enrollees must maintain a current State of Michigan nursing license and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201- 17242.
2. PDN may include medication administration according to MCL 333.7103(1).
3. This service must be ordered by a physician, physician's assistant, or nurse practitioner.
4. Through a person-centered planning process, the ICO shall determine the amount, scope and duration of services provided.
5. The direct service provider shall maintain close contact with the authorizing ICO to promptly report changes in each enrollee's condition and/or treatment needs upon observation of such changes.
6. The direct service provider shall send case notes to the care coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the care coordinator on the condition of the enrollee.
7. This service may include medication administration as defined under MCL 333.7103(1).

8. The ICO is responsible for assuring there is a physician order for the private duty nursing services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the ICO is responsible for assuring the PDN provider has a copy of these orders and delivers PDN services according to the orders.
9. The ICO shall maintain a copy of the physician orders in the Care Bridge Record.
10. **PDN is limited to 16 hours per day.**
11. Enrollees receiving Preventive Nursing Services are not eligible to receive Private Duty Nursing Services.
12. All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.
13. The enrollee's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the ICO and provider agency to assure services are delivered according to that order.
14. Services covered under the waiver shall not replace services that could be provided by the ICO in accordance with the Medicaid State Plan or Medicare.
15. For provider qualifications, refer to Appendix 7.

19.17.3. Minimum Standards for Self-Determined Service Delivery

When authorizing Private Duty Nursing for enrollees choosing the self-determination option, the ICO must comply with rules described in the Minimum Standards for Traditional Service Delivery in addition to the rest of the service definition as specified above.

19.18 Respite (provided at the enrollee's home or in the home of another person)

Respite (provided at the enrollee's home or in the home of another person)	
Description	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.
HCPCS Codes	**S5150**, Unskilled respite care, not hospice, per 15 minutes
Units	S5150 = 15 minutes
Service Delivery Options	☑ Traditional ☑ Self-Determination

19.18.1. Minimum Standards for Traditional Service Delivery

1. 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 <u>unpaid</u> care.**
2. **Only the <u>unpaid</u> care may be replaced with respite.**
3. Enrollees choosing the traditional method of service delivery **<u>may not</u>** choose to have respite furnished in the home of another.
4. The ICO must establish and follow written eligibility criteria for in-home respite that include, at a minimum:
    a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
    b. Enrollees have difficulty performing or are unable to perform activities of daily living without assistance.

5. Respite services include:
   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.

   The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the enrollee needs. Each ICO or direct service provider shall ensure the skills and training of the respite provider assigned are appropriate for the condition and needs of the enrollee.
6. With the assistance of the enrollee and/or enrollee's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each enrollee, pursuant to each visit for emergencies and provider no-shows or late arrivals.
7. Each direct service provider shall establish written procedures that govern the medication assistance given by staff to enrollees. 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. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his or her family's responsibility 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.
8. Each direct service provider shall employ a professionally

qualified supervisor that is available to staff during their shift while providing respite care.

9. Members of an enrollee's family who are not the enrollee's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize MI Health Link funds to pay for services furnished to an enrollee by that person's spouse, guardian or other legally or financially responsible individual. (Legally responsible person includes any person who has a duty under State law to care for another person and typically includes: the parent of a minor child or the guardian of a minor child who must provide care to the child or a spouse of the waiver participant.)
10. Family members who provide respite services must meet the same standards as providers who are unrelated to the enrollee.
11. The ICO shall not authorize respite services to relieve a caregiver that receives MI Health Link funds to provide another service to the waiver enrollee. For example, if the ICO has authorized a daughter to provide 20 hours per week of expanded community living supports to the enrollee and pays for this service with MI Health Link funds, the ICO shall not also authorize additional hours of respite to relieve the daughter of her caregiver duties. Rather, the ICO should decrease the daughter's paid hours and authorize another caregiver to provide the needed services and support to the enrollee. This requirement may be waived if:
    a. The case record demonstrates the enrollee has a medical need for supports and services in excess of the authorized amount of waiver services (i.e. in the example above the enrollee has a medical need for 50 hours per week of services); and
    b. The case record demonstrates the paid caregiver furnishes unpaid supports and services to the enrollee (i.e. the daughter is paid for 20 hours per week, but actually delivers 50 hours per week of services); and
    c. The paid caregiver is requesting respite for the supports and services not usually authorized through the waiver (i.e. for all or part of the 20 hours of medically necessary, but unpaid services the daughter regularly furnishes).
12. 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.
13. Respite services cannot be scheduled on a daily basis

14. 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
15. When a caregiver is unable to furnish unpaid medically-necessary services on a regular basis, the ICO should work with the enrollee and caregiver to develop an Individual Integrated Care and Supports Plan (IICSP) that includes other waiver services, as appropriate.
16. **The costs of room and board are not included.**
17. For provider qualifications, refer to Appendix 7.

19.18.2. Minimum Standards for Self-Determined Service Delivery

18. Enrollee's choosing this method of service delivery **may** choose to have respite services delivered in the home of another.
19. When authorizing Respite services for enrollees choosing the self-determination option, the ICO must comply with the rules described in the service definition and Minimum Standards for Traditional Service Delivery specified above.

19.19 Respite (provided outside of the home)

Respite (provided outside of the home)	
Description	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.
HCPCS Codes	**H0045**, Respite services not in the home, per diem
Units	H0045 = per day
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.19.1. Minimum Standards for Traditional Service Delivery

1. 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.
2. Each out-of-home respite service provider must be a licensed setting as defined in MCL 400.701ff, which includes adult foster care homes and homes for the aged. Respite may also be provided in a nursing facility.
3. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home, licensed Home for the Aged, or nursing facility.
4. Each ICO must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:
    a. Enrollees must require continual supervision to live in their own homes or the home of a primary caregiver or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable.
    b. Enrollees have difficulty performing or are unable

to perform activities of daily living without assistance.

5. Respite services include:
   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. The direct service provider must obtain a copy of the assessment conducted by the ICO before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite care support services the enrollee needs.
7. With the assistance of the enrollee and/or enrollee's caregiver, the ICO and/or direct service provider shall determine an emergency notification and contingency plan for each enrollee for emergencies.
8. Each direct service provider shall establish written procedures to govern assistance given by staff to enrollees who need help with medications. 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 in taking either 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. The enrollee shall maintain all medications in their original, labeled containers.
   c. Instructions for entering medication information in enrollee files.
   d. A clear statement of the enrollee's and his or her family's responsibility regarding medications taken by the enrollee while at the facility and the provision for informing the enrollee and his or her family of the program's procedures and responsibilities regarding assisted self-administration of medications.
9. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff.
10. MDHHS does not intend Respite services to be furnished

on a continual basis. Respite services should be utilized for the sole purpose of providing temporary, intermittent relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically-necessary services on a regular basis, the ICO should work with the enrollee and caregiver to develop a plan of service that includes other waiver services, as appropriate.

11. For each enrollee, the ICO shall not authorize MI Health Link payment for more than 30 days of out-of-home respite service per calendar year.
12. Respite services cannot be continually scheduled on a daily basis. Out of home respite may be scheduled for several days in a row, depending upon the needs of the enrollee and the enrollee's caregivers.
13. The ICO shall not authorize MI Health Link funds to pay for respite services provided by the enrollee's usual caregiver.
14. For provider qualifications, refer to Appendix 7.

19.20 Vehicle Modifications

Vehicle Modifications	
Description	This service covers adaptations or alterations to a vehicle that is the participant's primary means of transportation in order to meet the needs of the participant. Vehicle adaptations are identified in the person-centered service plan as necessary to enable the participant engage in the community, and ensure health, welfare and safety of the participant. The vehicle that is adapted may be owned by the participant, a family member with whom the participant lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services.
HCPCS Codes	**T2039**, Vehicle Modifications, waiver
Units	Per service, unless otherwise specified
Service Delivery Options	☑ Traditional ☐ Self-Determination

19.20.1. Minimum Standards for Traditional Service Delivery

1. The following are excluded:
    a. Adaptations or improvements to the vehicle that are of general utility and not of direct medical or remedial benefit to the participant.
    b. Purchase or lease of the vehicle
    c. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
2. The waiver agency and/or direct service provider must pursue payment by other sources, as applicable, before the waiver agency authorizes payment.
3. **$15,000 maximum for van lifts, including tie downs, for the duration of the 5-year waiver period.**
4. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of MI Health Link services.
5. The costs of necessary adaptations to provider vehicles may be compensated in the payment rate for transportation or other services (e.g., Community Living Supports, Adult Day Health, Residential Services) that include the cost of transportation.

20. HCBS Provider Reviews

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 through a contract renewal or review or other methodology (additional methodologies may include but would not be limited to obtaining a provider attestation of compliance with all applicable qualifications or reviewing provider documents to assure the provider meets qualification requirements for the delivery of MI Health Link services and confirm provider has active licenses and certification) that all providers can continue to meet the applicable qualifications and standards. Additionally, Integrated Care Organizations complete monitoring reviews for a percentage of their waiver service providers annually. The minimum percentage of waiver service providers that must be reviewed is listed in the annual MHL 1915c Waiver Application. Appendix 7 for complete Provider Monitoring Plan.

21. HCBS Waiver Enrollment Process

21.1 General Requirements

Each ICO should assign no more than five individuals to complete the waiver enrollment/disenrollment process within CHAMPS. These individuals are expected to review all waiver enrollment materials prior to submission to MDHHS to ensure completeness of the enrollment and all required materials are included in the submission. When a MI Health Link enrollee is interested in participating in the MI Health Link HCBS waiver, the ICO will enter HCBS waiver enrollments in CHAMPS pursuant to the 'HCBS in CHAMPS User Guide' (posted on SharePoint). Additionally, the ICO must upload an enrollment packet to MDHHS. The following materials must be included in the enrollment packet. (**Note: ICOs should limit document uploads to two files. One file containing power of attorney/durable power of attorney, or guardianship papers, and a separate file with the remaining required documents included under the admission/enrollment form.)**:

- Completed (or adopted) Nursing Facility Level of Care Determination (LOCD) tool in CHAMPS including the cover sheet checklist (see Appendix 3)
- Completed Freedom of Choice form (Section 1 by person conducting or adopting the tool, Section 2 by the enrollee)
- Completed MI Health Link HCBS Waiver Application and Consent Form (dated within 30 days prior to enrollment)
    - Enrollee must sign this form stating he or she is consenting to participate in the waiver and has been given information about various services and available providers
- Home Care (Level II) Assessment information
- Individual Integrated Care and Supports Plan (signature page dated within 30

days prior to enrollment)

- E-mail from MDHHS indicating residential and/or non-residential setting is compliant if applicable.
- **Note: Prior to submitting waiver enrollment in CHAMPS, the ICO must verify that the residential and/or non-residential setting is compliant.** This verification inquiry should be e-mailed to MDHHS-MHL-Waiver@michigan.gov mailbox with the name and address of the setting. Once MDHHS confirms that the setting is compliant, the ICO may proceed with entering the enrollment in CHAMPS. For these cases, the ICO should include the e-mail from MDHHS indicating the setting(s) are compliant with the enrollment packet upload when entering the enrollment in CHAMPS. If the ICO needs to complete a setting survey, it must be completed in person. Refer to the "HCBS Final Rule Requirements for Residential and Non-Residential Settings" section below in this document for details.
- Any active Power of Attorney, Durable Power of Attorney, guardianship papers if the individual cannot make decisions on his/her own.

The ICO will be notified by MDHHS if the enrollment packet is identified to be missing information, or additional information is required. MDHHS will communicate this information to each individual at the applicable ICO that has been identified by the ICO to complete waiver enrollment/dis-enrollments in CHAMPS.

Note: If an ICO is enrolling someone in the HCBS waiver during the deeming period, the ICO must alert MDHHS by sending an email to MDHHS-MHL-Waiver@michigan.gov and MDHHS-MHL-SR-ASSISTANCE@michigan.gov with the HCBS service start date. The ICO is responsible for completing all required assessments during the deeming period.

If the member is in deeming and it is determined that the member is eligible, MDHHS will enter the HCBS enrollment date, which will be determined on a case-by-case basis depending on the date that the member regains eligibility.

In addition, if eligibility is restored, MDHHS will enter the HCBS enrollment into CHAMPs and inform the ICO of a deadline to upload the waiver packet to the case. If eligibility is not restored, MDHHS will notify the ICO with the outcome and any needed next steps.

Non-Residential Settings: After a waiver enrollment has been entered, the ICO does not need to send additional waiver service requests to MDHHS except when the waiver participant requests an Adult Day Program. Before the ICO may provide Adult Day Program services, the name and address of the setting must be sent securely to MDHHS through the MDHHS-MHL-Waiver@michigan.gov mailbox. If there is no current Non-Residential Provider survey for that setting, MDHHS will notify the ICO to conduct the survey. The ICO must submit the completed survey to MDHHS-MHL-Waiver@michigan.gov mailbox and wait for MDHHS to determine whether the setting is

compliant with the HCBS Final Rule. If the setting is compliant, MDHHS will notify the ICO and Adult Day services may be provided in that setting. If the setting is not compliant, the enrollee will need to choose a different Adult Day setting. MDHHS must also determine whether the new setting is compliant before any services may be provided there. When a setting survey is due within the next month, MDHHS will notify the ICO via email that the annual survey needs to be conducted. MDHHS will include the setting name, due date and the setting survey template.

Residential Settings: If a waiver participant chooses to move into a provider-owned and controlled setting (such as an Adult Foster Care or Home for the Aged), the ICO must notify MDHHS of the upcoming move at least 30 calendar days prior to the move-in date. If the ICO has less notice, the ICO should notify MDHHS of the upcoming move as soon as possible. Before the ICO may provide any waiver services in the new setting, the name and address of the setting must be sent securely to MDHHS through the MDHHS-MHL-Waiver@michigan.gov mailbox. If there is no current Residential Provider survey for that setting, MDHHS will notify the ICO to conduct the survey. The ICO must submit the completed survey to MDHHS-MHL-Waiver@michigan.gov mailbox and wait for MDHHS to determine whether the setting is compliant with the HCBS Final Rule. If the setting is compliant, MDHHS will notify the ICO and waiver services may be provided in that setting. If the setting is not compliant, the enrollee may either choose to move to different setting, or he or she may choose to stop receiving waiver services in order to live in the noncompliant residential setting. Transitions from long term care facility to waiver: The ICO may enter the waiver enrollment in CHAMPS on the date of long term care facility discharge. When a setting survey is due within the next month, MDHHS will notify the ICO via email that the annual survey needs to be conducted. MDHHS will include the setting name, due date and the setting survey template.

21.2 Annual Recertification of Waiver Eligibility

Effective 01/01/2025, the ICO is no longer required to submit annual recertifications in CHAMPS. This does not alleviate the requirement for the ICO to conduct an annual LOCD and complete all required documents/ assessments on an annual basis.

21.3 Disenrolling an HCBS Waiver Enrollee

- When the ICO believes the individual no longer requires waiver services, the ICO must follow up with the enrollee to determine if additional services are needed before disenrolling from the waiver. If additional services are not needed, the ICO must update the IICSP accordingly and the IICSP must be signed by the enrollee (or his/her legal representative) and care coordinator.
- When an enrollee is no longer receiving HCBS Waiver services for whatever reason, the ICO must submit a disenrollment through

CHAMPS. The ICO must include the last date member received waiver services and (when indicated) the date of admission to either NF or hospital in the remarks box. The ICO must upload the required supporting documentation. The ICO cannot submit disenrollments until the appeal timeframe has been completed. ICOs should refer to MOS Section 4.1 for additional disenrollment guidance.

- Some reasons for HCBS Waiver disenrollment may be (not an exhaustive list):
  - Death
  - No longer requires waiver services due to change in condition or nature of the waiver services requested
  - No longer enrolled with the ICO
  - Has not received waiver services after approval for the waiver
  - Residing in a long term care facility or admitted to a hospital for one or more full months.
- When submitting the disenrollment when it has been determined the individual does not need additional services, the ICO must upload the updated IICSP including signature page in CHAMPS. For cases in which there was a death or ICO disenrollment, the ICO does not need to submit the updated IICSP.

21.4 HCBS Final Rule Requirements for Residential and Non-Residential Settings

The HCBS Final Rule applies to 1915(c) waiver programs. The ICO has been provided with the HCBS Final Rule Federal Register, CMS webinars, and other information regarding the rule. ICOs must comply with all requirements in the new Home and Community Based Services Chapter in the Medicaid Provider Manual and related policy Bulletin. The ICO must be familiar with all aspects of the HCBS Final Rule as it applies to the MI Health Link HCBS waiver. This compliance will be assessed prior to the individual's enrollment in the waiver. The ICO must utilize the standard statewide Provider Survey tool produced by MDHHS, in the Excel format. Licensed settings used for the Respite service do not need to be assessed unless the enrollee stays in the setting for more than 30days. If a survey was completed one year ago or more, the ICO must conduct a new survey via the Excel spreadsheet and submit it to MDHHS.

1. **Residential settings:**
   - All residential settings in which MI Health Link HCBS waiver enrollees live must comply with the requirements of the HCBS Final Rule.
   - If an enrollee has already been enrolled in the HCBS Waiver, and the enrollee later wishes to move to a different residential setting,

the ICO must check with MDHHS to see if the setting has been approved as compliant with the Final Rule. The ICO can do this by:

- Contact MDHHS via the MDHHS-MHL-Waiver@michigan.gov mailbox with the name and address of the setting and ask MDHHS staff to look up the setting to determine if a compliance determination has been made. In these cases, MDHHS staff will indicate that the setting is compliant in the comment box within the CHAMPS enrollment.

- If an individual is already enrolled in the waiver and chooses to move to a setting that is not compliant with the HCBS Final Rule, he or she must disenroll from the HCBS Waiver. In order to remain enrolled in the HCBS Waiver, he or she would have to select a different setting that is compliant with the HCBS Waiver. Setting compliance must be determined prior to the enrollee moving to the setting.

2. <u>Non-Residential Settings:</u>

- All non-residential settings, such as Adult Day Program settings, must comply with the HCBS Final Rule.
- Adult Day Program settings must be verified by MDHHS for compliance with the HCBS Final Rule at the time of approval for the HCBS Waiver and annually thereafter.
- If an enrollee has already been enrolled in the HCBS Waiver, and the enrollee later wishes to participate in an Adult Day Program, the ICO must check with MDHHS to see if the setting has been approved as compliant with the Final Rule. The ICO can do this by:
- Contact MDHHS via the MDHHS-MHL-Waiver@michigan.gov mailbox with the name and address of the setting and ask MDHHS staff to look up the setting to determine if a compliance determination has been made. In these cases, MDHHS staff will indicate that the setting is compliant in the comment box within the CHAMPS enrollment.

21.5 Person-Centered Planning

The ICO must develop the Individual Integrated Care and Supports Plan (IICSP) before providing services. The enrollee must approve of all services in the service plan. The ICO must document enrollee approval and participation on the service plan. Refer to Appendix 3 and Appendix 4 for additional details and requirements for content, Appendix 5 for IICSP signature guidance, and Appendix 17 for Person-Centered Planning.

- Appendix 4: IICSP requirements for HCBS Waiver enrollees
- Appendix 5: IICSP requirements for general MI Health Link enrollees
- Appendix 6: IICSP Signature Guidance
- Appendix 17: Person-Centered Planning

ICOs must comply with all requirements in the new Home and Community Based Services Chapter in the Medicaid Provider Manual and related policy Bulletin.

21.6 Participation in Arrangements that Support Self- Determination

Individuals enrolled in the HCBS waiver have the opportunity to participate in arrangements that support self-determination for certain services as indicated in the service tables above. The ICO and subcontracted entities must follow the guidance set forth in the MI Health Link Self-Determination Implementation Technical Advisory document.

21.7 Quality Improvement Strategy

The ICO must comply with the performance monitoring requirements set forth in the MI Health Link HCBS waiver application. MDHHS will provide additional guidance about these requirements.

21.8 Waiver Support Application System

The ICO must utilize the waiver management database in the Waiver Support Application system for accessing historical information related to waiver enrollment prior to 1/1/2022. Training on this database is available within the WSA platform. **When approved users leave the organization, the organization must** submit a drop access request through the DSA to MDHHS within 2 business days via email so the individual can be removed from the system.

21.9 Waiver Slot Allocation

1. Because MI Health Link is being phased in during the first year of operation, the first year of the program has a different total number of waiver slots than subsequent years. Additional slots are available in the subsequent years of MI Health Link operation in the event all slots are used in the first year. Waiver years are based on waiver approval by CMS. The waiver was approved effective January 1, 2015, so this is the beginning of the waiver year 1 which runs through December 31, 2015. Each subsequent year will be based on the calendar year beginning January 1st and going through December 31st.
2. A small number of waiver slots is reserved for individuals who are at

imminent risk of nursing home placement or want to transition from a nursing home to a community setting and the ICO has no vacant slots.

3. Effective 1/1/2022 Waiver slot management will be conducted by MDHHS external to the WSA and reports will be shared with ICOs periodically. Waiver slots are allocated per region and divided among ICOs. The total number per region is proportionate to the number of potential MI Health Link enrollees per region as indicated in the data MDHHS provided to ICOs and PIHPs which is saved in the ICO/PIHP SharePoint site. The number of slots per region is divided equally among ICOs for initial implementation purposes. MDHHS reserves the right to adjust the number of slots based on regional and ICO-specific HCBS waiver utilization.
4. The number of enrollees served is determined in two ways: there is an unduplicated count and at any point in time count. The unduplicated number of enrollees is the total number of individuals that can be served over the course of the year. This includes the number of individuals who have been enrolled in the waiver and then were disenrolled from the waiver. If an individual comes on and off the waiver more than once during the year and keeps the same Medicaid ID, this person will only account for one slot towards the unduplicated count. The any point in time count is the number of enrollees that may be served at any given time during the waiver year.
5. MDHHS will be closely monitoring the number of waiver slots used and adjustments may be made as necessary.
6. MDHHS reserves the right to move an enrollee's waiver slot along with him or her to another ICO if he or she changes ICOs and the new ICO has no slots available. For example, if an individual is enrolled in the waiver with ICO 1 and decides to move to ICO 2, and ICO 2 has no vacant waiver slots, the waiver slot occupied at ICO 1 will be moved by MDHHS to ICO 2.

21.10 Provider No Shows and Gaps in Services

The ICO must have requirements in place for a contingency plan in the event of provider no-shows or unexpected gaps in service. Providers may be allowed to refuse to go to a house that is perceived to be structurally unsafe (e.g., imminent risk of the roof falling in, unsafe entrance/exit). The ICO and/or providers must have rules and protocol (e.g., notifying appropriate authorities like Adult Protective Services, or other state or local services) for certain situations that may cause the caregiver to refuse to enter the home.

21.11 Unlicensed Residential Settings

If the ICO encounters a congregate residential setting, like an assisted living or independent living facility, that is not licensed by the State of Michigan as an Adult Foster Care (AFC) or Home for the Aged (HFA) but should be based on criteria below, the ICO must report this to MDHHS MI Health Link staff or the Department of Licensing and Regulatory Affairs (LARA).

General setting criteria for settings that require licensing as AFC:

- The facility provides room and board, supervision, personal care and protection to 3 or more individuals for five or more days per week for two or more weeks per year for compensation.

General setting criteria for settings that require licensing as HFA:

- The facility provides room and board, supervision, personal care to 21 or more adults that are 60 years of age or older. If the setting is attached to a nursing facility, the license can be for less than 21 beds if the setting has fewer than 21 beds.

- Additional licensing criteria can be found here: Licensing & Permits

Any residential setting that provides the level of services mentioned above should not be providing services without a license from the State and should not be the residential or Respite setting for anyone applying for or enrolled in the HCBS Waiver. These settings should be reported to LARA using the information from the website below (Click on the link for how to file a complaint):

Complaints

As an alternative, ICOs may report the setting via the INTEGRATEDCARE@michigan.gov email box and MDHHS staff will forward the complaint to LARA.

For those unlicensed settings like assisted living or independent living facilities that are appropriately unlicensed (they do not meet the State's criteria for a setting that requires licensure), the ICO MUST conduct a Residential Setting Survey for the setting if the setting is a residence for an individual applying for or enrolled in the MI Health Link HCBS Waiver and submit the survey to MDHHS MI Health Link Waiver staff for review and approval. Refer to section IV above.

21.12 Additional Provider Requirements

1. The ICO must complete the state-approved assessment instrument for each enrollee according to established standards prior to beginning home-based supports and services. Direct providers of home-based supports and

services must avoid duplicating assessments of individual enrollees to the maximum extent possible. Providers of home-based supports and services must accept assessments conducted by the ICO and begin supports and services without having to conduct a separate assessment. The ICO must make every attempt to supply the providers of home-based services with enough information about each enrollee served by that organization to properly provide needed services.

2. Home-based service providers include those for Expanded Community Living Supports, Chore Services, Respite provided in the home, Personal Emergency Response System, Private Duty Nursing, Preventive Nursing Services, and Home Delivered Meals. Other community-based service providers are those for Adult Day Program, Environmental Modifications, Respite services provided outside the home, Adaptive Medical Equipment and Supplies, and Non-Medical Transportation.
3. Home-based service provider requirements:
    i. Home-based providers must have a supervisor available to direct care workers at all times while the worker is furnishing services to enrollees. The provider may offer supervisor availability by telephone. Home-based service providers must conduct in-home supervision of their staff at least twice per year. A qualified professional must conduct the supervisory visit.
    ii. The ICO and direct provider agencies of home-based services must require and thoroughly check references of paid staff that will enter homes of enrollees. Reference checks must be conducted prior to beginning services.
    iii. The ICO and/or providers of home-based services must conduct a criminal history screening through the Michigan State Police via ICHAT or some other method, and in accordance with Michigan Medicaid policy, for each paid or unpaid **direct access staff or other provider** who will be entering homes of enrollees. Criminal history screenings must be completed prior to beginning service delivery. ICOs must follow additional Medicaid policy once MDHHS systems are ready.
    iv. ICO staff and direct providers of home-based services must receive in-service training as often as needed to ensure person-centered practices. The ICO and providers must design the training so that it increases staff knowledge and understanding of the program and its enrollees and improves

staff skills at tasks performed in the provision of service. Training sessions and materials developed and offered by MDHHS must be utilized before training developed by the ICO or its providers. The ICOs and direct providers of home-based services must maintain comprehensive records identifying dates of training and topics covered in an agency training log, and/or in each employee's personnel file. The employer shall develop an individualized in-service training plan for each employee when performance evaluations indicate a need.

v. Each ICO and direct provider of home-based services will assure MDHHS that employees or volunteers who enter and work within enrollee homes abide by the following additional conditions and qualifications:

1. Service providers must have procedures in place for obtaining enrollee signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the ICO.
2. Direct service workers are prohibited from smoking in enrollee's homes.
3. Direct service workers must be able to communicate adequately and appropriately, both orally and in writing, with their employers and the enrollees they serve. This includes the ability to properly follow product instructions in carrying out direct service responsibilities (i.e. read grocery lists, identify items on grocery lists, and properly use cleaning and cooking products.)
4. Direct service workers must not threaten or coerce enrollees in any way. Failure to meet this standard is grounds for immediate termination.
5. Service contractors and direct service workers will be promptly informed of new service standards or any changes to current services standards.

4. Other Community-Based Service providers:

a. <u>Enrollee Records</u>

Each direct provider of community-based services must maintain enrollee records that contain, at a minimum:

i. A copy of the request for services.
ii. Pertinent medical, social, and/or functional enrollee information as necessary to the proper delivery of the

requested service.

iii. A description of the provided service, including the number of units and cost per unit, as applicable.

iv. The date(s) of service provision.

v. The total cost of each service provided.

5. Direct providers of community-based services must keep all enrollee records (written, electronic, or other) confidential in controlled access files for ten years from end of contract.

a. Notifying Enrollee of Rights
Each ICO or direct provider of home-based services must notify each enrollee, in writing, at the time service is initiated of his or her right to comment about service delivery or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the enrollee that they may file complaints of discrimination with the respective ICO, the U.S. Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights.

22. Additional Standards for Encounter Quality

22.1 DRIVE™ Tool License Requirement

1. Effective June 15, 2020, each ICO must maintain an active license for the Dashboard for Research, Insight, and Validation of Experience (DRIVE™) tool, licensed by MDHHS' vendor, Milliman.

22.2 Minimum Standards for Encounter Timeliness Reporting

2. ICOs must submit the previous month's adjudicated encounters by the 28th of the measurement month. For example:

Month of Submission/Measurement Month	Payment Adjudicated Month
May-19	Apr-19
Jun-19	May-19

3. ICOs must submit encounters that include the criteria in the tables below. For the timeliness requirement, MDHHS will consider all encounters where Medicaid paid at least $0.01 and all sub-capitated encounters with a Claim Adjustment Reason

Code (CARC) 24. ICOs are still expected to submit encounters that are not sub-capitated where Medicaid did not pay (Medicare-only), although these encounters are not considered for the timeliness report.

4. Only unique Transaction Control Numbers (TCNs) will be counted. Required criteria:

Institutional, Professional, Dental Encounters	Pharmacy Encounters

• Encounter is accepted and active
• Health Plan ID specific
  ◦ Includes all members billed with a Medicaid ID
  ◦ Paid date reported by Plan
	• Encounter is accepted and active
	• Health Plan ID specific
	• Includes all Members billed with a Medicaid ID
	• Date of Payment (Check Date

5. ICOs must meet the minimum volume of records accepted into the MDHHS data warehouse.
    - When plans do not meet the guidelines for timely encounter submission, they may request a review by sending an email to Encounter Processing (MDHHSEncounterData@michigan.gov), Encounter Quality (MDHHS-Encounter-Quality@michigan.gov) and Integrated Care (IntegratedCare@michigan.gov) mailboxes. The email should include the period for which they are requesting a review and why they deserve a 'Pass'.
    - Refer to Appendix 12 in this document for the algorithm to determine minimum volume and additional details on reporting criteria and processes.

22.3 Encounter Comparison Review

Annually, the ICO will complete an Encounter Comparison Process which will compare the accepted claims/encounters in the ICO's system to the accepted encounters in the MDHHS data warehouse by invoice type for the requested fiscal year. The universe of encounters included must include any zero-pay claims from the providers contracted under a capitated arrangement and encounters from any subcontractors who are delegated claims processing.

- The ICO ERN on list with match in MDHHS data warehouse. Calculation: Total number of matched ERN encounter records by invoice type / Total number of submitted ERN encounter records submitted by invoice type ≥ x%
- MDHHS data warehouse ERN with match on the ICO ERN list. Calculation: Total number of matched ERN encounter records by invoice type / Total number of ERN encounter records accepted in the data warehouse by invoice type ≥x%

22.4 Fiscal Intermediary Encounter Submissions

Fiscal Intermediaries (FIs) can be used for both personal care as well as HCBS

- Personal care services (non-waiver members): For these members, FI services are considered an administrative cost and should not be reported to MDHHS through encounters. Do not submit encounters using T2025 code for non-waiver members. Do not adjust the monetary amount reported for personal care services to account for the administrative cost.
- HCBS: For these members, FI services are treated as a distinct waiver service and must be reported to MDHHS through encounters. Report the T2025 code for waiver FI services + all

  services for which the member is self-determining. The T2025 code should never be

reported without accompanying waiver encounters.

23. Care Coordinator Qualifications

The ICO Care Coordinator must be either a Michigan Licensed registered nurse; Licensed nurse practitioner; Licensed physician's assistant; Limited Licensed Bachelor's prepared social worker; Licensed Bachelor's prepared social worker; Limited Licensed Master's prepared social worker; Licensed Master's prepared social worker or (effective June 1, 2019, pursuant to MSA 19-10) a Clinical Nurse Specialist.

24. Required Reporting of Abortions

Medicaid payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify (form MSA-4240 which can be found here: Certification for Induced Abortion that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

The MSA-4240 must be completed by the designated party and the ICO must submit all MSA- 4240s annually to MDHHS, via their contract manager, during the reporting period and retain the form for 10 years.

PLEASE NOTE: Only abortion Medicaid claims need to be included on the report. If the claim was covered by Medicare, it does not need to be included on the report. If there are no qualifying abortions to report please still submit MSA 0128, with your organization name, indicating this.

Reporting period: October 1st- September 30th of each year Due Date: 5 days following the end of the reporting period.

25. Oral Requests for Appeals

Section 2.11.3.5.1.3 of the Three-Way Contract requires ICOs to honor oral requests for appeal. When a plan receives an oral request for a standard (i.e. non-expedited) appeal, it should send the member confirmation of the appeal (including facts, reason for appeal etc.) in writing. (See Appendix 13 for Template) ICOs should not wait for the member to send a written follow-up or otherwise require a written response. The internal decision should be rendered within 30 days of the oral request as required by §2.11.3.5.3 of the Three-Way Contract.

26. Learning Management System

Integrated Care Organizations are responsible to ensure all training requirements are met according to the Three-Way Contract. See Appendix 16 for Learning Management System Contract Crosswalk. The Learning Management System can

be access at:

https://courses.mihealth.org/MIHealthLink/index.html

27. Person-Centered Planning

Person-Centered Planning is a process for planning and supporting a person receiving services that builds on the individual's desire to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The Person-Centered Planning Process is led by the person and involves families, friends, legal representative, and professionals as they desire or requires. The process must be conducted in person unless the Enrollee declines the opportunity to participate in person. See Appendix 17 for the MDHHS Integrated Care Division Person-Centered Planning Practice Guideline.

28. We Treat Hepatitis C Initiative

MDHHS announced a public health campaign called We Treat Hep C aimed at eliminating Hepatitis C Virus (HCV) in Michigan. A memo distributed by the Department August 16, 2021 (See Appendix 18) outlines the expectations for ICOs around outreach and care coordination related to this initiative.

29. Nursing Facility Quality Assurance Supplement (QAS) Payments

Effective 1/1/2022, ICOs may negotiate with Nursing Facilities to pay rates that vary from the Medicaid FFS rate as established by the Long Term Care Reimbursement Division of MDHHS for traditional Medicaid nursing home days of care. Consistent with 42 CFR '§438.6(c)(1)(iii)(b), the ICOs will provide a Quality Assurance Supplement (QAS) payment in addition to the per diem rate negotiated with Michigan nursing facilities for actual Medicaid nursing facility days provided to the MI Health Link enrollees. The QAS payment will be the ICO Medicaid nursing facility days multiplied by 21.76% of the variable cost component of the fee-for -service daily rate for each facility limited to the variable cost limit for private facilities. This methodology is consistent with methodology in the approved State Plan.

The Quality Assurance Supplement (QAS) for dates of service on or after 1/1/2022 will be paid through a directed payment as approved by CMS through the Section 438.6(c) preprint process. Any QAS payments made to Nursing Facilities for dates of service on or after 1/1/2022 for MI Health Link beneficiaries using the old methodology must be recouped/reconciled.

Details regarding the new methodology for QAS payments can be found in L22-17 and L22-18 as well as the Section 438.6(c) pre-printed located in Appendix 19.

30. Submission Matrix

ICOs are required to submit all documents by the deadlines as indicated in the submission requirements matrix. The most current version of the Matrix can be located on the MHL SharePoint site under 'Materials'. Please note- MDHHS will make continuous updates to the Matrix in SharePoint, as necessary.

31. Non-Emergency Medical Transportation

Effective December 27, 2021, Integrated Care Organizations must comply with requirements in the Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209 concerning Medicaid coverage of non-emergency medical transportation verification of provider and driving requirements must meet minimum requirements. The minimum requirements are:

1. Each provider or individual driver is not excluded from participation in any federal health care program, is not listed on the MDHHS sanctioned provider list, and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services; and
2. Each individual driver has a valid driver's license
3. Each provider and individual driver must not have been convicted under a federal or state law after August 21, 1916, for a felony criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and
4. Each provider and individual driver must disclose and report any felony conviction related to a controlled substance to the waiver agency; and
5. Each provider and individual driver must disclose to the waiver agency the driving history, including any traffic violations, of each individual driver employed by a provider, including any traffic violations.
6. Individual drivers who have ANY of the following convictions in the past two years will be excluded an as NEMT provider
    a. More than two moving violations
    b. Operating While Intoxicated (OWI)
    c. Driving Under the Influence (DUI)
7. Exception to the traffic violation exclusion:
    a. A family member with any of the traffic convictions listed may receive reimbursement for NEMT provided to a MI Health Link enrollee who is unable to consent because of an intellectual or development disability or legal guardianship, with the written consent of their legally responsible party.
    b. A family member with any of the traffic convictions listed may receive reimbursement for NEMT provided to a MI Health Link enrollee who is able to consent to the family member providing NEMT after the

convictions are disclosed to the enrollee and the enrollee signs an acknowledgement form.

8. Applicability:
    a. These requirements are not applicable to a public transit authority.
    b. These requirements are not applicable to the MI Health Link enrollee.
    c. These requirements are applicable to transportation network companies such as Uber or Lyft
    d. These requirements are applicable to a beneficiary's family members.
    e. These requirements are applicable to taxicab drivers.
9. Additional Resources to Use
    a. MDHHS Sanctioned Provider List (maintained by MDHHS)
    b. Federal DHHS OIG exclusions

32. Direct Care Worker Provider Pay Increase

Pursuant to the Three-Way Contract, ICOs shall increase their contracted rates relative to the wage being received by, or the starting wage offered to, a qualifying direct care worker on March 31, 2020. If the contractor was not in business in March 2020, the direct care worker must be paid at least minimum wage plus the premium pay amount. The rate increase will be paid through a directed payment as approved by CMS through the Section 438.6(c) preprint process. The applicable service providers are outlined in the Three-Way contract and the 438.6(c) preprint can be found in Appendix 20.

33. Doula Services

Pursuant to MMP 22-47 Doula services are a covered Medicaid benefit for effective dates of service on and after January 1, 2023. Doula services are provided as preventive services pursuant to 42 C.F.R. Section 440.130(c).

ICOs should reject claims from Doulas that are not enrolled in CHAMPS. If the ICO pays a claim and the rendering Doula is not enrolled in CHAMPS, the encounter would not reject for this reason, but an informational edit 1452 would set. If the edit is received, the plans should ensure that their contracted Doulas that receive reimbursement are enrolled.

34. Care Coordinator Caseload Limit Reporting Frequency and Process in Cases of Noncompliance

ICOs must submit to MDHHS the 'CC Caseload Limit Ratio Report' on a quarterly basis. Compliance is established as a "met or not met" standard. If an ICO ends a quarter with a 'not met' mark, or is out of compliance in any month, it must immediately begin to submit the report monthly to allow for increased monitoring through the CMT.

If the ICO returns to compliance by the end of the next reporting period, it may go back to reporting quarterly and no further action will be taken. Should an ICO be out of compliance for three consecutive months, the ICO may be subject to formal compliance action, including, but not limited to; receipt of a Notice of Non-Compliance, Request for Corrective Action Plan, Warning Letter, and/or other intermediate sanctions as defined in 42 CFR §438.702.

If the ICO is unable to comply with CC caseload ratio requirements due to constraints posed by providing services in a region or county that is classified as rural, it may make a request for a rural exception. Requests for rural exceptions should be submitted to the ICO's contract manager and should include, at minimum, the following information:

- Overview of compliance Issue
- Barriers keeping the ICO from compliance
- Steps taken to attempt to come into compliance
- Steps taken to mitigate effects of noncompliance on members
- Any additional information that the ICO would like MDHHS to consider

MDHHS will consider requests for rural exceptions and determine the flexibilities allowed on a case-by-case basis.

35. Dental Covered Services for Health Plans

Changes have been made to the dental covered services for health plans and FFS Medicaid. Refer to the Dental chapter of the MDHHS Medicaid Provider Manual for additional coverage information, the Medicaid Code and Rate Reference tool via the external links in CHAMPS, or the dental database on the MDHHS website for a list of covered procedure codes. Effective 4/1/2023 ICOs are required to reimburse participating providers at least the established Michigan Medicaid FFS rate for covered CDT codes. The FFS rate schedule can be found at: Dental Fee Schedule

36. Appendices

Appendix 1: Billing and Encounter Procedure Codes

Appendix 2: Freedom of Choice Form

Appendix 3: Supporting Documentation Guidance and Checklist for Nursing Facility Level of Care Determination Tool

Appendix 4: IICSP Requirements for HCBS Waiver Applicants/Enrollees

Appendix 5: IICSP Requirements for General MI Health Link Enrollees (not enrolled in the HCBS Waiver)

Appendix 6: IICSP Signature Guidance

Appendix 7: Provider Qualifications and Monitoring for MI Health Link Waiver Services and Supplemental Services

Appendix 8: Notification Process for Mandatory Exclusions of Personal Care Providers

Appendix 9: Process for the Termination and Summary Suspension of a Current Provider

Appendix 10: Notification Process for Permissive Exclusions

Appendix 11: Request for Correction to Waiver Enrollment

Appendix 12: Detailed Encounter Timeliness Requirements

Appendix 13: Oral Appeal Acknowledgement Template

Appendix 14: Personal Care Supplement Payment Invoice

Appendix 15: COVID-19 Related Time Limited Policy

Appendix 16: Learning Management System Contract Crosswalk

Appendix 17: Person-Centered Planning Practice Guideline

Appendix 18: We Treat Hep C Coordination Plan for MI Health Link

Appendix 19: Quality Assurance Supplement (QAS) Section 438.6(c) Pre-Print
Appendix 20: Provider Pay Section 438.6(c) Pre-Print

36.1 Appendix 1: Billing and Encounter Procedure Codes

36.1.1. Nursing Facilities

Information for provider billing and ICO encounter submission related to nursing facilities may be found at: Nursing Facilities Click on the "**Revenue Code Table**" link.

36.1.2. State Plan Personal Care Services

- Use procedure code T1019 for personal care services, per 15 minute increments.
- For personal care supplement payment:
    - The ICO must use the invoice provided by MDHHS. The ICO must give this invoice to Adult Foster Care and Homes for the Aged providers for billing purposes. This invoice will be returned to the ICO, and the ICO will pay the personal care supplement to the provider as appropriate. There must an invoice for each enrollee residing in one of these settings.
    - The ICO will need to track the amount and date paid to the Adult Foster Care home or Home for the Aged for each enrollee.
    - For personal care supplement payments, the ICO should use procedure code" T1019" (personal care services, per 15-min increments) with modifier "CG" (policy criteria applied).
    - The ICO may find Place of Service code "14" (Group Home) applicable in Loop 2300.
- The ICO must submit encounters for each enrollee based on the information on the invoice and using the codes provided by MDHHS.
- Encounters will require a diagnosis code as well. For ICD-9, MDHHS recommends "V60.89" (Other specified housing or economic circumstances) or "V60.4" (No other household member able to render care). For ICD-10, MDHHS recommends "Z74.1" (Need assistance with personal care) or "Z74.2" (No other household member able to render care).

36.1.3. MI Health Link HCBS Waiver and Supplemental Services

HCPCS/ CPT Code	HCPCS/ CPT Modifier	HCPCS/ CPT Code Description	Standardized Remark	Comment
A0130		Non-emergency transportation; wheelchair van; per trip	7001 Public Transportation	
A0130		Non-emergency transportation; wheelchair van; per trip	7002 Private Transportation	
A0130		Non-emergency transportation; wheelchair van; per trip	7003 Volunteer Transportation	
A4931		Oral Thermometer, Reusable, any type, each		
A4932		Rectal Thermometer, Reusable, any type, each		
A9300		Exercise Equipment		
B4100		Food thickener, administered orally, per ounce		
B4150	BO	Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8003 Liquid	1 can = 1 unit
B4150	BO	Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8004 Solid	100 calories = 1 unit
B4150	BO	Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit	8005 Bar	1 bar = 1 unit
E0160		Sitz type bath or equipment, portable, used with or without commode		
E0161		Sitz type bath or equipment, portable, used with or without commode, with faucet attachment		
E0210		Electric heat pad, standard		
E0215		Electric heat pad, moist		
E0242		Bathtub rail, floor base		
E0315		Bed accessory; board, table, or support device, any type		
E0627		Seat lift mechanism incorporated into a combination lift chair mechanism		

E0629		Separate seat lift mechanism for use with patient owned furniture - nonelectric		
E0745		Neuromuscular stimulator, electronic shock unit		per unit
E1300		Whirlpool, portable (over tub type)		per unit
E1310		Whirlpool, non-portable (built-in type)		per unit - installation charges may fall under another waiver code.
E1639		Scale, each		
H0045		Respite services not in the home, per diem	7500 Adult Foster Care	
H0045		Respite services not in the home, per diem	7501 Hospital	
H2015		Comprehensive community support services, per 15 minutes	5501 Includes transportation	
H2015		Comprehensive community support services, per 15 minutes	5502 Does not include transportation	
S0209		Wheelchair van, mileage, per mile	7001 Public Transportation	
S0209		Wheelchair van, mileage, per mile	7002 Private Transportation	
S0209		Wheelchair van, mileage, per mile	7003 Volunteer Transportation	
S0215		Non-emergency transportation, mileage, per mile	7001 Public Transportation	
S0215		Non-emergency transportation, mileage, per mile	7002 Private Transportation	
S0215		Non-emergency transportation, mileage, per mile	7003 Volunteer Transportation	
S5100		Day care services, adult, per 15 minutes	5501 Includes transportation	
S5100		Day care services, adult, per 15 minutes	5502 Does not include transportation	
S5101		Day care services; adult; per half day	5501 Includes transportation	
S5101		Day care services; adult; per half day	5502 Does not include transportation	

S5102		Day care services, adult, per diem	5501 Includes transportation	
S5102		Day care services, adult, per diem	5502 Does not include transportation	
S5120		Chore Services; per 15 minutes	6001 Duct Cleaning	
S5120		Chore Services; per 15 minutes	6002 Install Safety Equipment	
S5120		Chore Services; per 15 minutes	6003 Install Smoke Alarm	
S5120		Chore Services; per 15 minutes	6004 Window Installation	
S5120		Chore Services; per 15 minutes	6005 Window Repair	
S5120		Chore Services; per 15 minutes	6006 Replace/Repair Door Lock	
S5120		Chore Services; per 15 minutes	6007 Replace/Repair Window Catch	
S5120		Chore Services; per 15 minutes	6008 Replace/Repair Electrical	
S5120		Chore Services; per 15 minutes	6009 Replace/Repair Plumbing	
S5120		Chore Services; per 15 minutes	6010 Install Screens or Storm Windows	
S5120		Chore Services; per 15 minutes	6011 Install Storm Door	
S5120		Chore Services; per 15 minutes	6012 Pest Control	
S5120		Chore Services; per 15 minutes	6013 Snow or Ice Removal	
S5120		Chore Services; per 15 minutes	6014 Lawn Mowing or Raking	
S5120		Chore Services; per 15 minutes	6015 Heavy-Duty Household Chores	
S5120		Chore Services; per 15 minutes	6016 Install weather stripping	

S5120		Chore Services; per 15 minutes	6017 Caulk windows	
S5120		Chore Services; per 15 minutes	6018 Remove exterior safety hazard	
S5121		Chore Services; per diem	6001 Duct Cleaning	
S5121		Chore Services; per diem	6002 Install Safety Equipment	
S5121		Chore Services; per diem	6003 Install Smoke Alarm	
S5121		Chore Services; per diem	6004 Window Installation	
S5121		Chore Services; per diem	6005 Window Repair	
S5121		Chore Services; per diem	6006 Replace/Repair Door Lock	
S5121		Chore Services; per diem	6007 Replace/Repair Window Catch	
S5121		Chore Services; per diem	6008 Replace/Repair Electrical	
S5121		Chore Services; per diem	6009 Replace/Repair Plumbing	
S5121		Chore Services; per diem	6010 Install Screens or Storm Windows	
S5121		Chore Services; per diem	6011 Install Storm Door	
S5121		Chore Services; per diem	6012 Pest Control	
S5121		Chore Services; per diem	6013 Snow or Ice Removal	
S5121		Chore Services; per diem	6014 Lawn Mowing or Raking	
S5121		Chore Services; per diem	6015 Heavy-Duty Household Chores	
S5121		Chore Services; per diem	6016 Install weather stripping	

S5121		Chore Services; per diem	6017 Caulk windows	
S5121		Chore Services; per diem	6018 Remove exterior safety hazard	
S5150		Unskilled Respite Care, not Hospice, per 15 minutes	7502 Home of another	
S5150		Unskilled Respite Care, not Hospice, per 15 minutes	7503 Enrollee's home	
S5160		Emergency response system; installation and testing		
S5161		Emergency response system; service fee, per month (excludes installation and testing)		
S5162		Emergency response system; purchase only		
S5165		Home modifications, per service	5001 Bathroom Modification	
S5165		Home modifications, per service	5002 Kitchen Modification	
S5165		Home modifications, per service	5003 Specialized Door Locks	
S5165		Home modifications, per service	5004 Doorway Modification	
S5165		Home modifications, per service	5005 Equipment Installation Charge	
S5165		Home modifications, per service	5008 Outside Railings	
S5165		Home modifications, per service	5009 Telephone Conversion for PERS Unit	
S5165		Home modifications, per service	5010 Stair Lift	
S5165		Home modifications, per service	5011 Ramp Installation	
S5165		Home modifications, per service	5012 Ramp Repair	
S5165		Home modifications, per service	5013 Portable Ramp	
S5165		Home modifications, per service	5014 Safety Railings	
S5165		Home modifications, per service	5015 Wireless Door Alarm	

S5165		Home modifications, per service	5016 Specialized Electrical System Installation	
S5165		Home modifications, per service	5017 Specialized Plumbing System Installation	
S5165		Home modifications, per service	5018 Other Repair	
S5165		Home modifications, per service	5019 Weatherization	
S5165		Home modifications, per service	5020 Injury Prevention	
S5170		Home delivered meals, including preparation, per meal	8001 Hot/Frozen	
S5170		Home delivered meals, including preparation, per meal	8002 Cold	
S5170		Home delivered meals, including preparation, per meal	8003 Liquid	
S5170		Home delivered meals, including preparation, per meal	8008 Emergency	
S5170		Home delivered meals, including preparation, per meal	8009 Breakfast	
S5199		Personal care item, NOS, each	0100 Reacher	
S5199		Personal care item, NOS, each	0101 Shower Attachment	
S5199		Personal care item, NOS, each	0102 Back scrubber	
S5199		Personal care item, NOS, each	0103 Beverage Bud	
S5199		Personal care item, NOS, each	0104 Adaptive Clothing	
S5199		Personal care item, NOS, each	0105 Assistive dressing device	
S5199		Personal care item, NOS, each	0106 Specialized bedding	
S5199		Personal care item, NOS, each	0107 Hospital gown	
S5199		Personal care item, NOS, each	0108 Key holder	
S5199		Personal care item, NOS, each	0109 Nail clippers	
S5199		Personal care item, NOS, each	0110 Specialized Shampoo tray	
S5199		Personal care item, NOS, each	0111 Specialized basin	

S5199		Personal care item, NOS, each	0112 Specialized bib unit	
S5199		Personal care item, NOS, each	0113 Assistive device for performing personal care	
S5199		Personal care item, NOS, each	0114 In-bed Vacuumed Bath Unit	
T1000	TD	Private duty/independent nursing service(s); Licensed, up to 15 minutes		TD indicates RN
T1000	TE	Private duty/independent nursing service(s); Licensed, up to 15 minutes		TE indicates LPN
T1002		RN Services, up to 15 minutes		
T1003		LPN/LVN services, up to 15 minutes		
T1028		Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs		Use for assessment of possible domiciles for NF transition
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0200 Specialized turner or pointer, adaptive equipment	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0201 Mouth stick for TDD	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0202 Foot massaging unit	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0203 Talking timepiece	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0204 Adaptive or specialized communication device, retail purchase	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0205 Adaptive eating or drinking devices	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0206 Assistive dialing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0207 Book holder	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0208 Adaptive door opener	

T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0209 Specialized alarm or intercom	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0210 Medical alert bracelet	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0211 Adapted mirror	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0212 Automatic light	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0213 Smokeless ashtray	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0214 No slip stabilizing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0215 Assistive writing device	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0216 Weighted blanket	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0217 Back knobber	
T1999		Misc. Therapeutic items & supplies, retail purchases, NOC	0218 Other adaptive or assistive devices	
T2003		Non-Emergency Transportation; per encounter/trip	7001 Public Transportation	
T2003		Non-Emergency Transportation; per encounter/trip	7002 Private Transportation	
T2003		Non-Emergency Transportation; per encounter/trip	7003 Volunteer Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7001 Public Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7002 Private Transportation	
T2004		Non-emergency Transportation, commercial carrier, multi-pass	7003 Volunteer Transportation	
T2025		Waiver Services, NOS	8500 Fiscal Intermediary Services, per month	
T2025		Waiver Services, NOS	8501 Self-determination workman's compensation insurance fee	For use only with SD enrollment for WCI fees.

T2028		Specialized supply, NOS	0301 Specialized Cabinet	
T2028		Specialized supply, NOS	0302 Non-Orthotic Elbow pad	
T2028		Specialized supply, NOS	0303 Non-Orthotic Knee pad	
T2028		Specialized supply, NOS	0304 Lap Tray not for wheelchair	
T2028		Specialized supply, NOS	0305 Tennis balls for use with walkers	
T2028		Specialized supply, NOS	0306 Water shield for cast	
T2028		Specialized supply, NOS	0307 Battery charger for specialized equipment	
T2028		Specialized supply, NOS	0308 Disinfectant	
T2028		Specialized supply, NOS	0309 Non-medical air filtering facial mask	
T2028		Specialized supply, NOS	0310 GT Feeding Plugs, not part of feeding system	
T2028		Specialized supply, NOS	0311 Specialized holders or cuffs for limbs	
T2028		Specialized supply, NOS	0312 Medication planner	
T2028		Specialized supply, NOS	0313 Pill crusher	
T2028		Specialized supply, NOS	0314 Non-slip mat or strip for bathtub	
T2028		Specialized supply, NOS	0315 Sharps container	
T2028		Specialized supply, NOS	0316 Electrostatic Air Filter	
T2028		Specialized supply, NOS	0317 Quantity above SP PA denial on file	
T2028		Specialized supply, NOS	0318 Stethoscope	
T2028		Specialized supply, NOS	0319 Non-Orthotic back support	

T2028		Specialized supply, NOS	0320 Electrodes for neuromuscular stimulator	To be used in conjunction with E0745
T2029		Specialized medical equipment, NOS	0400 Bumper pad	
T2029		Specialized medical equipment, NOS	0401 Air cushion ring	
T2029		Specialized medical equipment, NOS	0402 Electric cart	
T2029		Specialized medical equipment, NOS	0403 Geri Chair	
T2029		Specialized medical equipment, NOS	0404 Shower Stool with Back	
T2029		Specialized medical equipment, NOS	0405 Portable easy up	
T2029		Specialized medical equipment, NOS	0406 Safety frame for toilet	
T2029		Specialized medical equipment, NOS	0407 Walker Accessories; tray, basket, apron	
T2029		Specialized medical equipment, NOS	0408 Air Filtering Machine	
T2029		Specialized medical equipment, NOS	0409 Pressure relieving boot for decubitus care	
T2029		Specialized medical equipment, NOS	0410 Electronic Pill Dispenser	
T2029		Specialized medical equipment, NOS	0411 Humidifier not used with oxygen equipment	
T2029		Specialized medical equipment, NOS	0412 Dehumidifier not used with oxygen equipment	
T2029		Specialized medical equipment, NOS	0413 Specialized holder for insulin syringes	
T2029		Specialized medical equipment, NOS	0414 Palm cone	
T2029		Specialized medical equipment, NOS	0415 Air Conditioner	
T2029		Specialized medical equipment, NOS	0416 Air Purifier	
T2029		Specialized medical equipment, NOS	0417 Lift Chair Repair	

T2029		Specialized medical equipment, NOS	0418 Wheelchair stabilizer in vehicle	
T2029		Specialized medical equipment, NOS	0419 Installation of Elec Pill Dispenser	
T2029		Specialized medical equipment, NOS	0420 SP PA denied copy of denial on file	
T2029		Specialized medical equipment, NOS	0421 Specialized patient lift	
T2029		Specialized medical equipment, NOS	0422 Pivot Disk	
T2029		Specialized medical equipment, NOS	0423 Over-tub sliding bath system	
T2029		Specialized medical equipment, NOS	0424 Bath system accessory	
T2029		Specialized medical equipment, NOS	0425 Incentive Spirometer	
T2029		Specialized medical equipment, NOS	0426 Personal locator unit	
T2038		Community Transition, per service	9006 Appliance	
T2038		Community Transition, per service	9009 Household Supplies	
T2038		Community Transition, per service	9010 Moving Expenses	
T2038		Community Transition, per service	9014 Furniture	
T2038		Community Transition, per service	9015 Groceries	
T2038		Community Transition, per service	9016 Roof Repair	
T2038		Community Transition, per service	9018 Smoke Alarm	

T2038		Community Transition, per service	9021 Clothing	
T2038		Community Transition, per service	9022 Interpreter	
T2038		Community Transition, per service	9026 Fire Extinguisher	
T2038		Community Transition, per service	9029 Court Fees for Conservator/Guardian	
T2038		Community Transition, per service	9030 Carbon monoxide detector	
T2038		Community Transition, per service	9500 Coordination and support, per month	
T2038		Community Transition, per service	9501 Utility installation fee	
T2038		Community Transition, per service	9502 Utility deposit	
T2038		Community Transition, per service	9503 Linens	
T2038		Community Transition, per service	9504 Pest eradication service	
T2038		Community Transition, per service	9505 Allergen control service	
T2038		Community Transition, per service	9506 Residential cleaning service	
T2038		Community Transition, per service	9507 Individualized training for provision of care in home, per 15 minutes.	
T2038		Community Transition, per service	9508 Ramp, including installation	
T2038		Community Transition, per service	9509 Home Modification	
T2038		Community Transition, per service	9510 NFT Prescriptions, short term only	
T2038		Community Transition, per service	9512 NFT Credit Check	
T2038		Community Transition, per service	9513 NFT Application Processing Fee	

T2038		Community Transition, per service	9514 NFT Transportation	
T2038		Community Transition, per service	9516 NFT PCA for NF therapeutic leave days, per 15 min	
T2038		Community Transition, per service	9518 Community Placement Coordination	
T2038		Community Transition, per service	9909 NFTI Security Deposit	
T2038		Community Transition, per service	9910 NFTI Section 8 Voucher	
T2039		Vehicle Modifications, waiver, per service	9001 Water Heater	
V5268		Assistive listening device, telephone amplifier, any type	9002 Equipment Repair	
V5269		Assistive listening device, alerting, any type	9003 Hand Control Unit for Hospital Bed	
V5270		Assistive listening device, television amplifier, any type	9004 Power Converter Pack	
T5999		Individual Directed Goods and Services	9005 Wheelchair Accessories	If medically necessary
T5999	RR	Individual Directed Goods and Services	9005 Wheelchair Accessories	RR=Rental
T5999		Individual Directed Goods and Services	9006 Appliance	
T5999		Individual Directed Goods and Services	9007 Personal Hygiene Item	
T5999		Individual Directed Goods and Services	9008 Masseuse	Per 15 minutes
T5999		Individual Directed Goods and Services	9009 Household Supplies	
T5999		Individual Directed Goods and Services	9010 Moving Expenses	
T5999		Individual Directed Goods and Services	9011 Repair Service	
T5999		Individual Directed Goods and Services	9012 Water Therapy	
T5999		Individual Directed Goods and Services	9013 Utility Services	
T5999		Individual Directed Goods and Services	9014 Furniture	

T5999	RR	Individual Directed Goods and Services	9014 Furniture	RR= Rental
T5999		Individual Directed Goods and Services	9015 Groceries	In emergencies only
T5999		Individual Directed Goods and Services	9016 Roof Repair	If no other funding source
T5999		Individual Directed Goods and Services	9017 Safety Gate	
T5999		Individual Directed Goods and Services	9018 Smoke Alarm	
T5999		Individual Directed Goods and Services	9019 Electric Fan	
T5999		Individual Directed Goods and Services	9020 Financial Management	Per 15 minutes
T5999		Individual Directed Goods and Services	9021 Clothing	
T5999		Individual Directed Goods and Services	9023 Emergency Meal	
T5999		Individual Directed Goods and Services	9024 Protective Apron	
T5999		Individual Directed Goods and Services	9025 Step Stool	
T5999		Individual Directed Goods and Services	9026 Fire Extinguisher	
T5999		Individual Directed Goods and Services	9028 Magnifier	
T5999		Individual Directed Goods and Services	9029 Court Fees for Conservator/Guardian	
T5999		Individual Directed Goods and Services	9030 Carbon monoxide detector	
T5999		Individual Directed Goods and Services	9031 Specialty Camp	
T5999		Individual Directed Goods and Services	9033 SD advertisement for workers	
T5999		Individual Directed Goods and Services	9034 SD one-time payment for workers	
T5999		Individual Directed Goods and Services	9035 Social Isolation Remedy	

2.1 Appendix 2: Freedom of Choice Form

Refer to the MDHHS LOCD Webpage for most recent supporting documentation guide.

The webpage may be located at Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

2.2 Appendix 3: Supporting Documentation Guidance and Checklist for LOCD Tool

Refer to the MDHHS LOCD Webpage for most recent supporting documentation guide and job aids related to Verification and Secondary Review. The webpage may be located at: Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

The NFLOCD checklist required to be included with LOCD in the MHL HCBS Waiver Packet is below:

Nursing Facility Level of Care Determination Tool (LOCD) Guidance and Checklist

This guidance lists the supporting documentation that must be included when submitting a Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) to MDHHS for review with an HCBS waiver enrollment.

When submitting the supporting documentation to MDHHS, ICOs must also include this checklist document as a cover sheet for the submission and place a check mark by each piece of material included in the submission to MDHHS. This will serve as a checklist to ensure all appropriate documentation has been submitted.

Documents Required with Every LOCD

ICOs are required to submit the following with every LOCD:

- ❑ The completed and signed Freedom of Choice form
- ❑ The Level 1 Assessment
- ❑ The current care plan
- ❑ All documentation listed below for the LOCD door that the enrollee appears to meet.

All supporting documentation must cover the timeframe of the LOCD look-back period (either 7 or 14 days depending on the qualifying door). If a piece of required documentation cannot be submitted, the ICO must notify MDHHS and additional instructions will be provided. For this notification, ICOs may include a note directly on this document or attach a separate document with explanation.

Documents Required with Every LOCD

❑ **Door 1 (ADLs)**

Waiver

- ❑ InterRAI-HC (Level II) assessment
- ❑ Personal Care assessment

- ❑ **Door 2 (Cognitive Performance)**

  Waiver

  - ❑ InterRAI-HC (Level II) assessment
  - ❑ Completed cognitive tool, such as the Mini Mental Status Exam (MMSE), Brief Interview for Mental Status (BIMS), or St. Louis University Mental Status Examination (SLUMS).
  - ❑ Care coordinator notes detailing specific examples of enrollee's impaired decision-making abilities. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

- ❑ **Door 3 (Physician Involvement)**

  Waiver

  - ❑ Copies of appointment records for the physicians, nurse practitioners, and physician's assistants that the enrollee has visited in the past 14 days. Do not count emergency room examinations or hospitalizations.
  - ❑ Copies of new orders and order changes that were made by the enrollee's providers in the past 14 days. Order changes must take place on more than one day. **If the enrollee has multiple physician visits and multiple order changes on the same day, this counts as one physician visit and one order change per day.** Do not include drug or treatment order renewals that did not change. Do not count physician orders in the emergency room.

- ❑ **Door 4 (Treatments and Conditions)**

  Waiver

  - ❑ **Stage 3-4 pressure sores:**
    - ❑ Current wound care orders
    - ❑ Current wound care progress notes
    - ❑ Physician documented diagnosis of Stage 3 or 4 pressure ulcer.
  - ❑ **IV or parenteral feedings:**
    - ❑ Current physician order for feedings
    - ❑ Physician documented diagnosis of health condition causing need for feedings.
  - ❑ **Intravenous medications:**
    - ❑ Current physician orders for intravenous medications
    - ❑ Physician documented diagnosis of health condition causing need for IV medications.
  - ❑ **End-Stage care (waiver enrollees only):**
    - ❑ Documentation **signed by the hospice enrollment physician** certifying that the enrollee has a terminal illness with a prognosis of six months or less.
  - ❑ **Daily tracheostomy care, daily respiratory care, daily suctioning:**

- ❑ Current physician orders regarding daily trach care, respiratory care, or suctioning.
- ❑ Physician documented diagnosis of health condition causing need for daily trach care, daily respiratory care, or daily suctioning.

❑ **Pneumonia within the last 14 days:**

- ❑ Physician-documented pneumonia diagnosis **within last 14 days.**
- ❑ Documentation showing a need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or restorative nursing care **related to the pneumonia**.

❑ **Daily oxygen therapy:**

- ❑ Current physician order for oxygen.
- ❑ Physician-documented diagnosis of health condition causing need for oxygen.
- ❑ Documentation showing a need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or restorative nursing care **related to need for oxygen**.

❑ **Daily insulin with two order changes in the last 14 days:**

- ❑ Order changes for daily insulin **within last 14 days**.
- ❑ Physician-documented diagnosis of health condition causing need for insulin.

❑ **Peritoneal or hemodialysis:**

- ❑ Current physician order for dialysis.
- ❑ Physician-documented diagnosis of health condition causing need for dialysis.
- ❑ Documentation showing a need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or restorative nursing care **related to need for dialysis**.

❑ Door 5 (Skilled Rehabilitation Therapies)

Waiver

- ❑ Physical, Occupational, and/or Speech Therapy assessment(s) including amount of therapy administered and amount scheduled.
- ❑ Physician orders for Physical, Occupational, and/or Speech Therapy **covering the 7 day look-back period**.

❑ Door 6 (Behaviors)

Waiver

- ❑ InterRAI-HC (Level II) assessment
- ❑ Care coordinator notes showing history of wandering, verbal abuse, physical abuse, socially inappropriate/disruptive behaviors, resisting care, delusions, or hallucinations

during the 7 day look-back period. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

- ❑ Psychiatric consult notes or other physician notes (if available).

❑ **Door 7 (Service Dependency)**

Waiver

- ❑ Detailed documentation showing that the beneficiary requires ongoing services to maintain current functional status. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

❑ **Door 8 (Exception Criteria)**

Waiver

❑ **Frailty:**

- ❑ Documentation of the unreasonable amount of time which enrollee needs to perform bed mobility, toileting, transferring, or eating activities independently.
  - Things to consider and possibly send to MDHHS for review as applicable: Amount of time to perform any of the ADLs listed, not the ability level to perform it. Look for something in the record that documented the amount of time it took the beneficiary to perform the ADL (even if they were independent in that ADL) and if it was an unreasonable amount of time (five real minutes or longer). Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.
- ❑ Documentation showing that the enrollee's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.
  - Things to consider and possibly send to MDHHS for review as applicable: check the record to see if ADL performance, although independent and/or not a time constraint, impacted the individual's breathing which lead to consistent shortness of breath, pain and debilitating weakness. The individual has to be impacted by shortness of breath, pain, debilitating weakness for at least 15 real minutes. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.
- ❑ Documentation showing that the enrollee has fallen two or more times in their home in the past month.
  - Things to consider and possibly send to MDHHS for review as applicable: the falls must be associated with dizziness, lightheadedness, gait problems or symptoms that are routinely experienced. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.
- ❑ Documentation showing that the enrollee is unable to manage his/her own medication administration despite receiving medication set-up services.
  - Things to consider and possibly send to MDHHS for review as applicable: medication management typically does not apply because nursing facilities administer medications. Residents are asked upon admission if they would like to self-medicate but most choose not to do so. For persons in the community, the individual would have to have medication management for at least one month, but still experienced

health issues related to managing those medications (like mismanaging despite have medication set-up). Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

- ❑ Documentation showing that the enrollee has inadequate nutritional intake, such as continued weight loss, despite receiving meal preparation services.
  - Things to consider and possibly send to MDHHS for review as applicable: check to see if there was a significant weight loss (10 pounds or more) or signs of poor nutrition despite the fact that the beneficiary was receiving meal preparation for at least one month. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.
- ❑ Documentation showing that the enrollee meets the criteria for Door 3 when emergency room visits for clearly unstable conditions are considered.
  - Things to consider and possibly send to MDHHS for review as applicable: use the same criteria for Door 3 on the LOCD except that MDHHS permits emergency room visits to be counted for Door 8. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

❑ **Behaviors:**

- ❑ Documentation showing that the enrollee has at least a one month history of any of the following behaviors, and has exhibited two or more of any these behaviors in the last seven days, either one at a time or in combination:
  - Wandering
  - Verbal or physical abuse
  - Socially inappropriate behavior
  - Resists care
  - Things to consider and possibly send to MDHHS for review as applicable: Behaviors should be noted in the record by the Social Worker or Nurse. **When it comes to Resisting Care, be careful to account for the fact that enrollees have the right to refuse a treatment plan**; that's not really resisting care. Resisting care is defined in the LOCD (pushing, shoving, scratching, etc). Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

❑ **Treatments:**

- ❑ Documentation demonstrating that the enrollee has a need for complex treatments or nursing care. Notes or narratives must be signed and dated by the individual creating them – electronic signatures and dates are acceptable.

❑ Door 0 (Does not meet LOCD)

Waiver

- ❑ Detailed documentation describing the Care Coordinator's observations of the enrollee's current health status and physical capabilities. Include copies of any assessments or notes that the Care Coordinator reviewed. The Care Coordinator must report his/her findings pertaining to each door of the LOCD to demonstrate that the enrollee does not appear to meet the LOCD. Notes or narratives must be signed and

dated by the individual creating them – electronic signatures and dates are acceptable.

EXAMPLE OF CARE COORDINATOR DOCUMENTATION FOR DOOR 0 LOCDS:

Door 1: Enrollee is able to get in and out of bed by herself. She gets into and out of chairs independently. She does not need any assistance with toileting. She occasionally needs someone to cut up her food when the arthritis in her right hand is bothering her, but she is always able to feed herself.

Door 2: The enrollee was able to remember all three words of the short-term memory test after 5 minutes. She converses clearly and easily. She expressed no difficulty understanding the care coordinator during the assessment and was able to teach back the education the care coordinator provided on her high blood pressure medication. The enrollee was wearing weather-appropriate clothing and used her cane whenever she ambulated. She is able to keep track of her daily schedule without assistance. She is able to travel, manage her finances, and manage her medications independently.

Door 3: In the past 14 days, the enrollee has had two physician appointments and no order changes.

Door 4: The enrollee does not have any of the treatments or conditions listed. She uses oxygen at night about twice per week but does not need it every day.

Door 5: Enrollee does not have a need for physical, occupational, or speech therapy at this time. She has no therapies ordered.

Door 6: The enrollee has not displayed wandering, verbal abuse, physical abuse, socially inappropriate/disruptive behaviors, resisting care, delusions, or hallucinations over the past 7 days per enrollee and her caregiver. The enrollee denies having a history of behavioral health conditions.

Door 7: The enrollee has not been in PACE, MI Choice, the MI Health Link HCBS waiver, or a nursing home for one year.

Door 8: The enrollee does not meet any of the Exception Criteria. She is able to complete her Activities of Daily Living in a reasonable amount of time. The enrollee experiences occasional shortness of breath during daily activities but it does not prevent her from completing activities. The enrollee experiences mild chronic pain due to arthritis in her hand, but it is well controlled and does not prevent her from completing her daily activities. The enrollee has not had any falls in the past month. The enrollee is able to manage her own medications. The enrollee's weight has been stable for the past 3 years and she eats at least two meals per day. The enrollee has not had any emergency room visits in the past year. The enrollee did not provide or show any evidence of wandering, verbal abuse, physical abuse, socially inappropriate behavior, or resisting care in the past month or past week. The enrollee did not provide or show any evidence of a need for complex treatments or nursing care.

Signed Acknowledgement

I have attached all required documents to the waiver packet to support the waiver enrollment.

Name of healthcare professional completing checklist

Healthcare Profession Title

Date

2.3 Appendix 4: IICSP Requirements for HCBS Waiver Applicants/Enrollees

The Individual Integrated Care and Supports Plan, or IICSP, is the most important care coordination tool in the MI Health Link program. It is a comprehensive document that allows the enrollee, ICO Care Coordinator, providers, and others to stay current with the enrollee's overall status and the progress of his/her goals and treatments.

The following information may be placed in the IICSP in any order as long as all required pieces are present. The basis for the following requirements is found in the 3-Way Contract and the HCBS Final Rule.

1. **Section 1: Required Content for all Waiver IICSPs**

   a. **Understandable, plain language**. Make sure to simplify medical terms and write out acronyms (example: Write "high blood pressure" instead of hypertension or HTN). The IICSP must also be understandable to persons with disabilities or limited English proficiency (example: Use large print for vision problems).

   b. **IICSP completion date**- also include on separate documents that are part of the plan.

   c. **Contact information** for the ICO Care Coordinator, primary care physician, and personal care workers. If applicable, include contact information for the legal representative.

   d. **Health status summary** including all of the enrollee's needs. Include medical, social, behavioral health, supports, service, dietary, and other needs. The enrollee's needs must be addressed in the goals/objectives.

   e. **Residential status** including the type of home the enrollee lives in, whether the home is owned or rented, and a statement showing that the enrollee chooses to live there.

   f. **Preferences** about supports, services, caregivers, religious and cultural practices, social activities, contact with the Care Coordinator, and any other preferences.

   g. **Strengths chosen by the enrollee** (examples: good appetite, positive outlook, exercises twice per week).

   h. **Concerns expressed by the enrollee** (examples: keeping BP under control, staying independent as long as possible, wants to keep living in current home). Concerns must be addressed in the goals/objectives.

   i. **Risk factors** and the **interventions** that will help to reduce the enrollee's risks. Include a **backup plan** for caregiver absences, severe weather, fires, or other emergencies. Include the **name** of the backup caregiver or agency. Risk reduction must be addressed in the goals/objectives.

   j. **Monitoring** that will help to manage the enrollee's health conditions, risks,

concerns, and other issues. List each specific monitoring task with its **due date** and the **name** of whoever will be doing that monitoring task. Include the **due date** of the next IICSP review and the **name** of the person responsible for monitoring the IICSP.

k. The enrollee's **goals, objectives, and desired outcomes written in a measurable and achievable form**. Include **interventions** that will help the enrollee to meet his/her goals, objectives and outcomes. List each specific intervention with its **due date** and the **name** of whoever is responsible for that intervention.

l. **ALL supports and services.** Include a brief description of the service, **how much** of each service will be provided, **how often**, and for **how long**. Include the **reasons** that the enrollee needs each service and the **names of the service providers**.

    i. When the enrollee needs Personal Care services, list the Activities of Daily Living and other activities that the enrollee will get help with. Include the total number of Personal Care units that the enrollee is approved for per week, with a breakdown of the number of units for each specific activity. The care plan must state how much help the enrollee needs for each activity (examples: limited assistance, extensive assistance, total assistance).

m. A list of **due dates for reassessments** and the **name(s)** of whomever is responsible for the reassessments.

n. A Nursing Facility Transition Plan if providing Community Transition Services to transition to Waiver.

o. Per 42 CFR 441.301(c)(2)(ix) The final copy of the IICSP must be signed by the enrollee, the care coordinator, and all providers involved in the implementation of the IICSP. This includes those providing the services contained in the IICSP (applicable to direct providers). Direct providers (for the purposes of IICSP signatures) are defined as those providing services in which they have ongoing direct contact with the beneficiary and include: adult day program, ECLS, preventive nursing services, private duty nursing, respite, and personal care services. When an agency/entity is involved, a representative of the agency/entity may sign the IICSP. Note: an example of an entity would be an AFC home.

    Additionally, a Fiscal Intermediary (FI) is not a direct service provider. An FI handles the business end of securing services and supports. The FI is not responsible for implementing the IICSP and is not able to sign the IICSP on behalf of a caregiver. An FI is facilitating the employment of the service worker, and the service worker is responsible for implementing and signing the IICSP.

    Per 42 CFR 441.301(c)(2)(x) The person-centered service plan must be distributed to the individual and other people involved in the plan. It is the ICO's responsibility to distribute the IICSP to the designated representative for an agency/entity that will be rendering services and not to each individual employee of that entity. It is the

entity's responsibility to inform staff in a manner that ensures they have the critical information to render services, respect the individual and ensure his/her health and welfare.

It is the expectation that the entire care plan is provided. If the individual requests a provider not receive the full plan it must be documented in the plan and the individual must sign that they have requested the action. However, when that occurs the ICO must confirm with the individual that they have selected this specific provider for services.

The ICO may use the MDHHS-5515 (Consent to Share Behavioral Health Information for Care Coordination Purposes) as applicable in conjunction with IICSP development to give the beneficiary freedom of choice with how any behavioral health and/or stance use disorder related information in the IICSP is shared.

Individuals that are providing informal or natural supports must receive information (either from the enrollee or the care coordinator) on the services they are responsible for delivering, an understanding of how these services fit into the larger plan, and emergency information so that the health and welfare of the beneficiary is protected.

a. If the enrollee/representative will be taking responsibility to notify the supports of their responsibilities, this must be indicated in the care plan and the enrollee must sign
b. If the enrollee is delegating to the care coordinator the task of notifying the supports of their responsibilities, this must be indicated in the care plan and the care coordinator must document that it has been done.

Note: MDHHS will take a phased approach to enforcing compliance with the requirements of 42 CFR 441.301(c)(2)(ix) and 42 CFR 441.301(c)(2)(x). MDHHS staff reviewing waiver enrollments will note to the ICO when the IICSP does not contain all required signatures and will work with ICOs to come into compliance.

2. Section 2: Required IICSP Content for Specific Waiver Services

a. When the **Adult Day Program** is requested, include:
    i. How the enrollee will be transported to and from the Adult Day Program.
    ii. The days and times that the enrollee will attend the program every week.
    iii. Documentation about whether the enrollee got to choose an Adult Day Program from multiple options. If no, why?
    iv. Documentation about whether the enrollee was given information on how to request a new Adult Day Program. If no, why?
    v. Documentation about whether all individuals at the setting have a documented, person-centered service plan. If no, why?

b. When **Assistive Technology** is requested, include:
    i. A detailed description of the item(s) that will be covered through this service.

c. When **Chore Services** are requested, include:

i. Documentation that no other person, including a landlord or a person living in the enrollee's home, is responsible for providing Chore Services.

ii. Documentation that no other person is able and willing to provide Chore Services for the enrollee.

d. When **Environmental Modifications** are requested, include:

i. Documentation that the landlord is not responsible for providing Environmental Modifications (for rental properties only).

e. When **Expanded Community Living Supports (ECLS)** is requested, include:

i. When the enrollee needs ECLS, list the Activities of Daily Living and other activities that the enrollee will get help with. Include the total number of ECLS units that the enrollee is approved for per week, with a breakdown of the number of units for each specific activity. The care plan must state how much help the enrollee needs for each activity (examples: supervision, prompting, cueing).

f. When the **Fiscal Intermediary** is requested, include:

i. The enrollee's individual budget and the waiver services that the enrollee will buy using the budget.
ii. Documentation about what responsibilities the enrollee wants the Fiscal Intermediary to have.
iii. Indicate that the individual has chosen to participate in an arrangement that supports self-determination.

g. When **Home Delivered Meals** are requested, include:

i. Documentation showing that the enrollee is not able to make his/her own meals.
ii. Documentation showing that the enrollee can feed him/herself.
iii. Information about special dietary needs.
iv. Documentation showing that there is no person living in the home or a caregiver who is able and willing to make meals for the enrollee.

h. When **Non-Medical Transportation** is requested, include:

i. A list of the types of activities this service will be used for (i.e. shopping, church, visiting family, etc).
ii. Documentation that the enrollee does not have any other transportation

for those activities.

i. When the **Personal Emergency Response System** is requested, include:

   i. The risks that are causing the enrollee to need a PERS.
   ii. Information about the regular periods of time that the enrollee is alone at home, **OR** information showing that any other person living in the home is not able to call for help in an emergency.

j. When **Preventive Nursing** is requested, include:

   i. A description of the health condition that will be managed using Preventive Nursing visits. The IICSP must state why the enrollee needs this health condition monitored.
   ii. A list of the assessments or other monitoring that will be done during each visit.
   iii. Descriptions of the nursing interventions that will be carried out during each visit to manage the enrollee's chronic health condition.
   iv. Descriptions of any other nursing tasks that will be carried out during visits.
   v. Information telling the enrollee what to do if his/her health condition worsens in between Preventive Nursing visits.

k. When **Private Duty Nursing** is requested, include:

   i. A description of the Medical Criteria that qualify the enrollee for this service (see the *Minimum Operating Standards for MI Health Link*).
   ii. The number of hours that the nurse will spend at the enrollee's home each day.
   iii. Descriptions of the interventions that the nurse will complete for the enrollee.

l. When **Respite** is requested, include:

   i. Information about the name and responsibilities of the caregiver who is being replaced by the Respite caregiver. This information must show that the regular caregiver is **not** paid for the services he/she provides. If the regular caregiver provides both paid and unpaid care, list the times when unpaid care is provided. **Only the unpaid care may be replaced using the Respite service.**
   ii. Documentation showing that the enrollee needs supervision during the time Respite is being provided, **OR** that the enrollee needs a different caregiver when his/her regular caregiver is not available.
   iii. Documentation showing that the enrollee needs help with at least one Activity of Daily Living.
   iv. The location where the enrollee will receive Respite.
   v. An estimate of how often Respite will be used.

3. Section 3: Required IICSP Content for Enrollees Living in a Provider Owned/Controlled Residential Setting

a. A **provider owned/controlled residential setting** is a place in the community, such as an Adult Foster Care or Home for the Aged, where both housing and healthcare services are provided to the residents. By choosing to live in this type

of setting, a MI Health Link enrollee is choosing to receive services from the provider who owns the setting.

b. **When an enrollee lives in a provider owned/controlled setting, the IICSP must contain:**

   i. The name of the setting

   ii. Information about the enrollee's financial resources. The enrollee's preferences about how he/she lives. This includes preferences about his/her daily schedule, bathroom schedules, roommates, and more.

   iii. The enrollee's preferences for taking part in community activities. State what activities the enrollee wants to take part in, how he/she will get there, and whether the enrollee needs support to take part in the activities. State whether the enrollee needs help getting transportation or finding work.

   iv. Any risks that affect the enrollee's ability to take part in community activities without supervision. Include interventions that will reduce the risks. Example: an enrollee with dementia has a companion so that he can go out to dinner safely.

   v. Documentation showing that when the enrollee requires accommodations or restrictions that are contrary to HCBS Final Rule requirements and federal regulations, the accommodations or restrictions **are based on the enrollee's needs** as found through his/her assessments. The IICSP must set up timeframes for periodic reviews of the accommodations or restrictions.

   vi. Documentation stating whether the enrollee got to choose a place to live from multiple options. If no, why?

   vii. Documentation stating whether the enrollee had the chance to choose housing with a private bedroom. If no, why?

   viii. Documentation stating whether the enrollee was given information on how to request new housing. If no, why?

   ix. Documentation stating whether all individuals in the setting have a documented, person-centered service plan. If no, why?

c. **The following seven conditions apply to waiver participants living in provider owned/controlled settings.** Sometimes, these conditions may need to be modified in order to meet the enrollee's personal needs. These conditions can only be modified if the enrollee's needs are documented in his/her assessments and IICSP.

   i. The enrollee owns, rents, or occupies his/her living unit under a legal agreement, and the enrollee has the same responsibilities and protections from eviction that tenants have under the landlord/tenant

law. For settings in which landlord/tenant laws do not apply, a written residency agreement is in place for the enrollee that provides protections that address eviction processes and appeals comparable to those provided under the landlord/tenant law.

ii. The enrollee has privacy in his/her sleeping or living unit.

iii. The enrollee can lock the entrance door to his/her unit. Only appropriate staff have keys to this door.

iv. If the enrollee chooses to live in a setting with shared units, the enrollee is able to choose his/her roommate, if possible. If this isn't possible immediately upon moving into the setting, it still should be identified as something the enrollee wishes to pursue in the future if the opportunity arises.

v. The enrollee has the freedom to furnish and decorate his/her sleeping or living unit as allowed by the lease or other residency agreement.

vi. The enrollee has the freedom and support to control his/her own schedule and activities. The enrollee also has access to food at any time.

vii. The enrollee is able to have visitors of his/her choosing at any time.

d. **When any of the seven conditions from 3.c.i-vii are changed, the IICSP must contain:**

i. Documentation showing that the change was based on the enrollee's personal needs as found during his/her assessments. **Example:** Gladys lives in an Adult Foster Care. During the Level I assessment, the Care Coordinator learns that Gladys tries to cook on the stove and burns herself every time she goes into the kitchen. Her "need" is to remain safe while in the kitchen.

ii. Documentation about the positive interventions and supports that were tried before changing any of the conditions. **Example:** The Adult Foster Care staff and the ICO Care Coordinator tried multiple times to teach Gladys how to use the stove safely. The staff reviewed the lessons every time Gladys wanted to cook.

iii. Documentation about less restrictive ways of meeting the enrollee's need that were tried but did not work. **Example:** The Adult Foster Care staff began checking on Gladys every 5-10 minutes whenever she was in the kitchen. They continued to explain how to use the stove safely.

iv. A description of the condition that is being changed and why the enrollee needs it to be changed. **Example:** Gladys was unable to learn safe cooking skills after many lessons. Her kitchen access is restricted to times that staff are able to supervise her. The **condition** that needs a change in this case is "The enrollee has the freedom and support to control his/her own schedule and activities. The enrollee also has access to food at any time". The **reason** that Gladys needs this change is that she cannot use

the stove alone without being harmed and staff are not always available to assist her.

v. Documentation showing that the ICO Care Coordinator is regularly checking to see if the change is working for the enrollee. The results of these checks must be included in the IICSP.

vi. Due dates for periodic reviews to see if the change is still necessary. **Example:** The ICO Care Coordinator checks every three months to see if Gladys still needs supervision when in the kitchen. This is included in the IICSP as one of the Care Coordinator's monitoring responsibilities.

vii. Document the informed consent of the enrollee (or legal representative) to the changed condition.

viii. A statement from the ICO Care Coordinator that none of the interventions or supports that are used will cause harm to the enrollee. **Example:** The IICSP includes a statement that Gladys will not lose weight or have any other negative effects due to her restricted kitchen access.

2.4 Appendix 5: IICSP Requirements for General MI Health Link Enrollees (Not enrolled in the HCBS Waiver)

The Individual Integrated Care and Supports Plan, or IICSP, is the most important care coordination tool in the MI Health Link program. It is a comprehensive document that allows the enrollee, ICO Care Coordinator, providers, and others to stay current with the enrollee's overall status and the progress of his/her goals and treatments. The basis for these requirements is the 3-Way Contract. The following information may be placed in the IICSP in any order as long as all required pieces are present.

1. **Required Content for all MI Health Link IICSPs**

   a. **Understandable, plain language**. Make sure to simplify medical terms and write out acronyms (example: Write "high blood pressure" instead of hypertension or HTN).

   b. **IICSP completion date**- also include on separate documents that are part of the plan.

   c. **Contact information** for the ICO Care Coordinator, primary care physician, and personal care workers. If applicable, include contact information for the legal representative.

   d. **Health status summary** including all of the enrollee's needs. Include medical, social, behavioral health, supports, service, dietary, and other needs. The enrollee's needs must be addressed in the goals/objectives.

   e. **Preferences** about supports, services, caregivers, religious and cultural practices, social activities, contact with the Care Coordinator, and any other preferences.

   f. **Strengths chosen by the enrollee** (examples: good appetite, positive outlook, exercises twice per week).

   g. **Concerns expressed by the enrollee** (examples: keeping BP under control, staying independent as long as possible, wants to keep living in current home). Concerns must be addressed in the goals/objectives.

   h. **Monitoring** that will help to manage the enrollee's health conditions, risks, concerns, and other issues. List each specific monitoring task with its due date and the name of whoever will be doing that monitoring task. Include the **due date** of the next IICSP review and the **name** of the person responsible for monitoring the IICSP.

   i. The enrollee's **goals, objectives, and desired outcomes written in a measurable and achievable form**. Include **interventions** that will help the enrollee to meet his/her goals, objectives and outcomes. List each specific intervention with its due date and the name of whoever is responsible for that intervention.

   j. **ALL supports and services.** Include **how much** of each service will be provided, **how often**, and for **how long**. Include the **reasons** that the enrollee needs each service and the **names of the service providers**. Include a Nursing

Facility Transition Plan if providing Community Transition Services

ix. When the enrollee needs Personal Care services, list the Activities of Daily Living and other activities that the enrollee will get help with. Include the total number of Personal Care units that the enrollee is approved for per week, with a breakdown of the number of units for each specific activity. The care plan must state how much help the enrollee needs for each activity (examples: limited assistance, extensive assistance, total assistance).

k. A list of **due dates for reassessments** and the **name(s)** of whoever is responsible for the reassessments.

2.5 Appendix 6: IICSP Signature Guidance

Per 2.1.2.1.2 of the 3-Way Contract, the ICO must: "Comply with all applicable provisions of federal and State laws, policies, regulations, guidance, waivers and standards, and Demonstration terms and conditions, including the implementation of a compliance plan".

This guidance pertains to the requirements of MI Health Link for obtaining enrollee signatures when completing or making changes to Individual Integrated Care and Supports Plans (IISCPs). All documentation surrounding IICSP discussions, including discussions of beneficiary rights and choices, will be maintained in the Integrated Care Bridge Record (ICBR). All enrollees must be provided a copy of the final IICSP. Any requirement in this guidance calling for an enrollee's signature may be interpreted to include, and be fulfilled by, the signature of an authorized representative, such as a guardian or person legally appointed by the enrollee to act on his/her behalf.

A. MI Health Link HCBS waiver participants

1. Pursuant to the HCBS Final Rule, Section 441.301 (2)(ix)-(x), the person-centered service plan 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 person-centered service plan must be distributed to the individual and other people involved in the plan.'** This indicates that the final copy of the initial IICSP must be signed by the enrollee, the care coordinator, and all providers involved in the implementation of the IICSP and in providing the services contained in the IICSP. See Appendix 4 for additional guidance related to obtaining signatures and distribution of the plan. ICOs may obtain a signature from a member at the end of the same meeting where the IICSP is created if the IICSP is final at that time.
2. Whenever changes are made to the IICSP, the new IICSP must be discussed with and signed by appropriate individuals as mentioned above (per the HCBS Final Rule). Note: Non-substantial grammatical and formatting changes to the IICSP are permissible even after a member signature has been obtained.
3. IICSP discussions must be documented in detail and maintained in the ICBR.

4. Signatures can be obtained from the member at the same time as the IICSP development meeting as long as the IICSP is final before leaving the home. If changes are made to the IICSP following that meeting, the member must be contacted, informed of changes made, and progress note from the care coordinator must be kept in the ICBR noting the member was informed of and accepting of the changes made. The progress note date must match the signature date and must include the following information: specific IICSP/revisions discussed, beneficiary's agreement to the IICSP/revisions, date/time of call, and the care coordinator's signature.
5. Acceptable methods of signatures under HCBS waiver:
6. In Person
    i. The member/authorized representative signs the final copy of the IICSP
7. Electronically
    i. Electronic signatures must be obtained annually and not saved to be reused. ICOs must maintain a policy that describes standards for acceptable electronic signatures that complies with federal and state regulations.
8. By mail
    i. This is acceptable if the IICSP is developed in person with the member/authorized representative, but additional formatting is required to finalize the document before signature.
    ii. Also acceptable if developed in person, but guardian/authorized representative is in a different location which prevents them from signing in person. Representative should be present when IICSP is developed.

B. MHL members not on HCBS waiver

Whether the IICSP completion/revision process takes place in person OR telephonically (according to guidelines) the ICO may obtain the IICSP signature/acceptance once the IICSP is finalized. ICOs may obtain a signature from a member at the end of the same meeting where the IICSP is created if the IICSP is final at that time. The Care Coordinator must also sign the IICSP. Note: Non-substantial grammatical and formatting changes to the IICSP are permissible even after a member signature has been obtained.

Signatures may be obtained either:

1. In Person
    i. The member signs the final copy of the IICSP.
2. FaceTime/Skype
    i. A progress note by the care coordinator documenting the specific IICSP/revisions that were discussed, the beneficiary's agreement with the IICSP/revisions, the date/time, and the care coordinator's signature.
3. Via Mail

i. If the IICSP was mailed for the enrollee's signature, the ICO must have detailed documentation showing that a person-centered planning meeting took place to develop/revise the IICSP. The documentation must include the specific details which were discussed, including all care goals which were accepted and/or rejected by the enrollee. The documentation must also include the date/time, the care coordinator's signature, and must record the individual's agreement with the finalized IICSP. The ICO must send a self-addressed postage paid return envelope for the member to return the signed IICSP.

4. Verbally

i. By phone (two options available to the ICO to document verbal authorization). Note: the member does not need to have the final copy of the IICSP on their person in order to sign/accept verbally.

ii. A recording of the entire phone discussion (call logs not acceptable), which must include all care goals which were accepted and/or rejected by the enrollee and the individual's agreement with the finalized IICSP **or**

iii. A progress note by the care coordinator documenting the specific IICSP/ revisions that were discussed, the beneficiary's agreement with the IICSP/revisions, the date/time, and the care coordinator's signature.

C. **Unable to Locate Enrollees or Enrollees who Decline the IICSP**

a. No signature will be required on the IICSP. Inability to locate or declining participation must be documented in the ICBR.

2.6 Appendix 7: Provider Qualifications and Monitoring for MI Health Link HCBS Waiver and Supplemental Services

Provider qualification information as approved by CMS on January 2015 in the 1915c waiver application to CMS:

Service Name	Provider Qualifications
Adaptive Medical Equipment and Supplies	**Agency: Enrolled Medicaid and Medicare DMEPOS Provider**
	License: N/A **Certification:** N/A **Other:** Each direct service provider must enroll in Medicare and Medicaid as a Durable Medical Equipment/POS provider, pharmacy, etc., as appropriate. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.
	Agency: Retail Store
	License: N/A **Certificate:** N/A **Other:** 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.
Adult Day Program	**Adult Day Program Agency:**
	License: N/A **Certificate:** N/A **Other:** 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 individuals or organizations. 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 vehicle 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 program shall operate in compliance with P.A. 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 State of Michigan and local building codes. b. Fire safety standards. c. Applicable State of Michigan and local public health codes. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter
Assistive Technology	**Agency: Enrolled Medicaid and Medicare DMEPOS Provider**
	License: N/A **Certificate**: N/A **Other**: Each direct service provider must enroll in Medicare and Medicaid as a DMEPOS provider, pharmacy, etc., as appropriate. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.

	Agency: Retail Stores
	License: N/A **Certificate**: N/A **Other:** 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.
	Agency: Other Contracted or Subcontracted Provider
	License: N/A **Certificate:** N/A **Other:** The contracted/subcontracted 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.
Chore Services	**Agency: Contracted or subcontracted provider other than individuals**
	License: N/A **Certificate:** N/A **Other:** 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.
	Individuals chosen by the enrollee who meet qualification standards
	License: N/A **Certificate:** N/A **Other:** 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 MDCH operating standards. 3. Must be deemed capable of performing the required tasks by the ICO. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.

Environmental Modifications	**Individual: Contracted Provider, Licensed Building Contractors**
	License: MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2403(3) **Certificate:** N/A **Other:** **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to execution of contract.
Expanded Community Living Supports (ECLS)	**Individuals chosen by the enrollee who meet the qualification standards**
	License: N/A **Certificate**: N/A **Other:** 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
	Agency: Home Care Agency
	License: N/A **Certification:** N/A **Other:** 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-borne 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. MDCH 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. 6. Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
Fiscal Intermediary (FI)	**Agency** **License:** N/A **Certificate:** N/A **Other:** 1. Provider must be bonded and insured. 2. Insured for an amount that meets or exceeds the total budgetary amount the fiscal intermediary is responsible for administering. 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. Neither providers of other covered services to the enrollee, the family or guardians of the enrollee may 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. 3. Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.

Home Delivered Meals	**Agency: Home Delivered Meals Provider**
	License: Health Code Standards (PA 368 of 1978) **Certification:** N/A **Other:** 1. Each home delivered meals provider shall have the capacity to provide three 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. **Entity Responsible for Verification:** ICO **Frequency of Verification:** Prior to delivery of services and annually thereafter.
	Agency: Meal Delivery Kit Providers
	License: Health Code Standards (PA 368 of 1978) **Certification:** N/A **Other:** 1. Each Home Delivered Meals provider shall have the capacity to provide three 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 to cover 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. In Lieu of the meal delivery kit provider meeting this requirement, the ICO can establish an individualized back up plan to ensure that the enrollee receives meals from an alternate source in the event there is a disruption to the meal kit delivery. 3. Each provider shall carry product liability insurance sufficient to cover its operation. 4. The provider shall ensure food is delivered at safe temperatures as defined in Home Delivered Meals service standards. **Entity Responsible for Verification:** ICO **Frequency of Verification:** Prior to delivery of services and annually thereafter.
Individual Directed Goods and Services	**Agency: Retail Stores**
	License: N/A **Certificate: N/A** **Other:** 1. Items purchased from retail stores must meet the Goods and Services definition. 2. ICOs must be prudent with their purchases and may have a business

	account with the retail store. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
	Individual: Contracted Provider
	License: N/A **Certificate: N/A** **Other:** 1. Provider must be reputable and able to provide the good or service necessary. 2. Providers must be at least 18 years of age, have the ability to communicate effectively, have previous relevant experience or training to provide the good or service and be deemed capable of providing the good or service by the ICO. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to provision of services/execution of contract and annually if service is ongoing in nature.
Non-medical transportation	**Agency: Contracted Provider**
	License: Valid Michigan Driver's License **Other**: 1. The Secretary of State must appropriately license all drivers and register all vehicles used 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
	Individual Provider
	License: Valid Michigan Driver's License **Other**: 1. The Secretary of State must appropriately license all drivers and register all vehicles used 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. 3. Each provider shall operate in compliance with Public Act 1 of 1985 regarding seat belt usage. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.

Personal Emergency Response System	**Agency: Personal Emergency Response System Provider**
	License: N/A **Other**: 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. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
Preventive Nursing Services	**Agency: Home Care Agency**
	License: Nursing MCL 333.17201-17242 **Other**: 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. This service may include medication administration as defined under the referenced statutes. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
	Individual: Licensed Practical Nurse or Registered Nurse
	License: Nursing MCL 333.17201 ... 333.17242 **Other**: 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. This service may include medication administration as defined under the referenced statutes. 3. It is the responsibility of the LPN to secure the services of an RN to supervise his or her work. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.

Private Duty Nursing	**Agency: private duty nursing agency, home care agency**
	License: Nursing MCL 333.17201 ... 333.17242 **Certificate**: N/A **Other**: 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. This service may include medication administration as defined under the referenced statutes. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.
	Individual: Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)
	License: Nursing MCL 333.17201 ... 333.17242 **Certificate**: N/A **Other**: 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. This service may include medication administration as defined under the referenced statutes. 3. It is the responsibility of the LPN to secure the services of an RN to supervise his or her work. **Entity Responsible for Verification**: ICO **Frequency of Verification**: Prior to delivery of services and annually thereafter.

Respite	**Agency: Home Care Agency**
	When providing care in the home of the enrollee: When Chore Services or Expanded Community Living Supports are provided as a form of respite care, these services must also meet the requirements of the respective service category. 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: • 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. • Verification of prescription medications and their dosages. • Instructions for entering medication information in enrollee files. • 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. 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: **License**: Adult Foster Care: Act 218 of 1979; Homes for the Aged: MCL 333.21311; Nursing Home: MCL 333.21711 **Certificate**: Nursing home beds must be dually certified by Medicare and Medicaid **Other**: Each out of home respite service provider must be either a Medicaid certified hospital or a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged. Each direct service provider shall employ a professionally qualified program director that directly supervises program staff. 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. 5. Effective December 18, 2023, agencies and fiscal intermediaries that pay direct care workers who provide PCS must obtain a National Provider Identifier (NPI) and enroll in the Community Health Automated Medicaid Processing System (CHAMPS), in accordance with MDHHS Bulletin MMP 23-76. **Entity Responsible for Verification**: ICO
	Frequency of Verification: Prior to delivery of service and annually thereafter.
	Individual chosen by the enrollee who meets qualification standards

	1. When Chore Services or Expanded Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category. 2. Family members who provide respite services must meet the same standards as providers who are unrelated to the enrollee. 3. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions. **Entity Responsible for Verification:** ICO **Frequency of Verification**: Prior to delivery of service and annually thereafter.

MI HEALTH LINK PROVIDER MONITORING PLAN

PROVIDER REVIEWS

Integrated Care Organizations are responsible for conducting monitoring of their waiver service providers to ensure compliance with provider qualifications and standards. Integrated Care Organizations are responsible to ensure provider compliance prior to delivery of service and annually thereafter. Integrated Care Organizations complete monitoring reviews on all new providers prior to delivery of service. Integrated Care Organizations ensure on an annual basis through a contract renewal or review or other methodology (Additional methodologies may include but would not be limited to obtaining a provider attestation of compliance with all applicable qualifications or reviewing provider documents to assure the provider meets qualification requirements for the delivery of MI Health Link services and confirm provider has active licenses and certification) that all providers can continue to meet the applicable qualifications and standards. Additionally, Integrated Care Organizations complete monitoring reviews for a percentage of their waiver service providers annually. The minimum percentage of waiver service providers that must be reviewed is listed in the annual MHL 1915c Waiver Application.

METHODOLOGY

The Integrated Care Organization assigns one or two staff that has primary responsibility for conducting provider reviews.

NEW PROVIDERS

The Integrated Care Organization 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 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.

The Integrated Care Organization 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 Integrated Care Organization 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 Integrated Care Organization has confirmed compliance. Additionally, for a provider that is non-compliant their notification must clearly indicate the findings and provide recommendations for corrective action. The Integrated Care Organization must establish due dates when the provider should be expected to be in full compliance with the qualifications and a date when the Integrated Care Organization will re-evaluate the provider's status. Once the Integrated Care Organization has determined the provider is compliant, they shall send a notification utilizing the MDHHS letter template to the provider.

The Integrated Care Organization must at the initial findings and provider notification letter within 30 days to the Michigan Department of Health and Human Services (MDHHS) via the ICO FTP utilizing the file name "provider monitoring." Additionally, the Integrated Care Organization must submit any additional communication/findings related to the monitoring including the final compliance letter.

ALL PROVIDERS

Annually, the Integrated Care Organization ensures either through their contract renewal process or a contract review with the provider that the provider continues to be compliant with all applicable provider qualifications. If a provider is determined to not be compliant, the Integrated Care Organization must notify the provider and MDHHS following the same process as noted above for 'new providers'. This process should be reflected in the Integrated Care Organization's Provider Monitoring Policy.

SAMPLED SUBSET OF PROVIDERS

Integrated Care Organizations complete monitoring reviews for a minimum sample of their waiver service providers annually. The Integrated Care Organization develops a yearly schedule of provider monitoring reviews to conduct monthly throughout the calendar year, January 1 to December 31. 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.
- 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.

The Integrated Care Organization 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 Integrated Care Organization to be compliant or non-compliant with the applicable qualifications. Additionally, for a provider that is non-compliant their notification must clearly indicate the findings and provide recommendations for corrective action. The Integrated Care Organization must establish due dates when the provider should be expected to be in full compliance with the qualifications and a date when the Integrated Care Organization will re-evaluate the provider's status. Once the Integrated Care Organization has determined the provider is compliant, they shall send a notification utilizing the MDHHS letter template to the provider.

The Integrated Care Organization must submit the initial findings and provider notification letter within 30 days to the Michigan Department of Health and Human Services (MDHHS) via the ICO FTP utilizing the file name "provider monitoring." Additionally, the Integrated Care Organization must submit any additional communication/findings related to the monitoring including the final compliance letter.

CORRECTIVE ACTION

- When findings warrant immediate action to protect the enrollee's health or welfare the Integrated Care Organization will suspend new referrals to the provider agency or transfer enrollees to another provider.
- When Billing Audit findings reveal non-compliance, the Integrated Care Organization must adjust provider billings using individual adjustments to date of service or gross adjustment. Deduct overpayments made to a provider from the

next warrant issued the provider from the Integrated Care Organization. Additionally, encounter data submitted to the Community Health Automated Medicaid Payment System (CHAMPS) must be corrected to accurately reflect adjustments made to provider billing.

- Integrated Care Organization must suspend or terminate the providers who demonstrate a failure to correct deficiencies identified through this process. The Integrated Care Organization can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required.

COORDINATION WITH CARE COORDINATORS

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.

COORDINATION WITH OTHER INTEGRATED CARE ORGANIZATIONS

Any time an Integrated Care Organization finds rationale to terminate a provider from the provider network the Integrated Care Organization must notify MDHHS of the findings and the reason for terminating the contract. This notification to MDHHS should be uploaded to the FTP utilizing the file name "provider monitoring." MDHHS will notify other Integrated Care Organizations as warranted. This is to mitigate potential harm to other MI Health Link enrollees.

2.7 Appendix 8: Notification Process for Mandatory Exclusion of Personal Care Provider

ICOs must conduct a background check for all personal care providers and applicants in accordance with the applicable 42 U.S. Code § 1320a–7, MDHHS policy (MSA 14-31 and 14-40), and Section 2.7.3 of the Three-Way Contract. If the background check identifies a mandatory exclusion for the provider or applicant, the ICO must follow this process to notify the provider or applicant, the enrollee, and MDHHS.

1. Provider/Applicant Notification Process

a. For a personal care provider coming from the Home Help program or an existing personal care provider in MI Health Link, the ICO will mail the advanced action notice for mandatory exclusion (template available in 'Mandatory Exclusion' folder on SharePoint) including MDHHS Policy Bulletins MSA 14-31 and MSA 14-40 and the excerpt from the applicable section of the US Code to the provider to allow for proper notification of the identified exclusion and appeal rights as a provider. The advanced action notice must be mailed to the provider within two business days of the ICO confirming the mandatory exclusion. Following an internal appeal with the ICO, the provider may be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR) for an external appeal.

    i. The ICO is responsible for services provided through the 10th business day following the date on the advanced action notice. The date on the notice will be counted as the first business day. The ICO will not make payment for services rendered beyond the 10th business day following the notification.

b. For a new personal care applicant, the ICO will mail the adequate action notice for mandatory exclusion (template available in 'Mandatory Exclusion' folder on sharepoint) including MDHHS Policy Bulletins MSA 14-31 and MSA 14-40 and the excerpt from the US Code to the applicant to allow for proper notification of the identified exclusion and appeal rights of the applicant. The adequate action notice must be mailed to the applicant within two business days of the ICO confirming the mandatory exclusion. Following an internal appeal with the ICO, the provider may be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR) for an external appeal.

    i. Payment will not be made for any services as the exclusion was determined prior to the applicant joining the ICO network and providing services.

2. Enrollee Notification Process

a. Within two business days of the ICO confirming the exclusion, the ICO care coordinator will contact the enrollee to determine a time to meet (preferably in person) to discuss the exclusion. The enrollee must be advised of the need to select another personal care provider because the provider or applicant with a mandatory exclusion cannot provide Medicaid services in either MI Health Link or the Home Help program. The discussion with the enrollee, including the selection of a new provider or applicant will be documented in the IICSP.

   i. The care coordinator should meet in person with the enrollee and anyone else the enrollee would like to involve in decisions regarding the personal care provider. It is suggested that the care coordinator prepare a list of eligible providers prior to the meeting so that the enrollee can be presented with multiple options for a new personal care provider.

   ii. The enrollee should be asked a general question about his or her preferences for a personal care giver. Consideration could be given to the provider's age, gender, and/or cultural, religious or ethnical preferences when selecting a new care provider. Discussing different providers that meet these preferences would help ensure that the enrollee feels he or she has appropriate options when the initial provider or applicant of choice is not able to provide care.

   iii. The care coordinator will explain that the enrollee may select someone already approved to provide personal care services or may select a new applicant who must also go through the criminal history screening process before payment is approved. This screening process is required by law and affects all providers of Medicaid personal care services including those provided in the Home Help and MI Health Link programs.

   iv. The care coordinator will inform the enrollee during the meeting that the ICO will be issuing a letter to the enrollee explaining the exclusion and need for a new provider as discussed in the meeting.

   v. The care coordinator must inform the enrollee during the meeting that a letter will be sent to the provider or applicant that explains the exclusion and the reason for the inability to provide services.

b. The ICO will send the enrollee written notification on the same day that the notification letter is sent to the provider/applicant explaining the exclusion,

including the timeframe for discontinuation of services and payment to the provider or no payment for an excluded applicant.

3. MDHHS Notification Process

a. The ICO will notify MDHHS of the mandatory exclusion by e-mailing the last four digits of the provider's or applicant's Social Security Number and a copy of the notification letter as an attachment to MSA-ICO-EXCLUSIONS@michigan.gov and to the contract manager.

i. The MI Health Link staff will maintain a list on SharePoint of excluded personal care providers and applicants so ICOs can avoid the need to repeat background checks on excluded individuals.

2.8 Appendix 9: Process for the Termination and Summary Suspension of a Current Provider

ICOs may receive a copy of a Notice of Termination of Provider Agreement or an Order of Summary Suspension and Notice of Termination of Provider Agreement directly from the Office of Inspector General (OIG). The OIG has determined that the provider will be suspended from the Medicaid program immediately to protect the state's interest in public health, welfare and safety; medically indigent individuals; and the public funds of the Medicaid program as stated in MCL 400.111f. Therefore, if the provider is in ICO's network or is a first-tier downstream related entity, the ICO will terminate the provider agreement and notify the enrollee(s) receiving services from the provider of such termination and summary suspension, when applicable.

1. **Provider Agreement Termination**

   i. The agreement between the ICO and the provider will be terminated in accordance with the date contained in the Notice of Termination. The provider will no longer be allowed any direct or indirect participation in the Michigan Medicaid Program including the MI Health Link program per the date in the termination notice.

   ii. The provider received notification of such action directly from MDHHS. The ICO would follow its process for notifying the sanctioned provider and terminating the ICO agreement with the provider.

   iii. The protections afforded to the enrollee to maintain a current provider under the continuity of care requirements are not applicable when the provider is subject to a termination.

2. **Summary Suspension**

   i. **All payments to the provider will be stopped immediately**. MCL 400.111f(5) states that an order may be issued for the summary suspension of payments on pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in the program of medical assistance. This includes payments for services that the provider has already provided, as DHHS will not reimburse a suspended provider for any services or items that were ordered, prescribed, referred, or rendered by a suspended provider. The ICO is prohibited from reimbursing the provider for **any previously provided services and/or unpaid claims** from the date of the summary suspension notice. The protections afforded to the enrollee to

maintain a current provider under the continuity of care requirements are not applicable when the provider is subject to a termination and summary suspension.

3. Enrollee Notification Process

i. The ICO care coordinator will meet (preferably in person when the terminated provider is a personal care service provider) with any enrollees currently receiving services from the suspended provider to discuss the suspension and the need to select another provider, as the provider will no longer be able to participate in the Medicaid program including the MI Health Link program. The discussion with each enrollee, including the newly selected provider will be documented in the IICSP.

   i. The Care Coordinator should meet in person with the enrollee and anyone else the enrollee would like to involve in selecting a new provider. It is suggested that the ICO to prepare a list of eligible providers prior to the meeting so that the enrollee can be presented with multiple options for a new provider. Discussing multiple providers that would fit the enrollee's preferences would help ensure that the enrollee feels he or she has other options when the initial provider of choice is no longer able to provide Medicaid services.

ii. The ICO will send the notification to the enrollee containing an explanation of the suspension and notification that the provider must stop providing services in accordance with the Notice of Termination and Order of Summary Suspension, if applicable.

2.9 Appendix 10: Notification Process for Permissive Exclusions

ICOs must conduct a background check for all personal care providers and applicants to ensure compliance with 42 U.S. Code § 1320a–7 and MDHHS policy (MSA 14-31 and 14-40). If the background check identifies a permissive exclusion for the provider or applicant, the ICO will follow this process to notify the enrollee and the provider or applicant. This guidance does not apply if the ICO has a general policy of not allowing providers with permissive exclusions to provide services.

1. Within two business days of the ICO confirming the exclusion, the ICO care coordinator will contact the enrollee to determine a time to meet (preferably in person) to discuss the permissive exclusion. The enrollee must be informed of the option to make a personal choice selection, that would allow the enrollee to continue receiving services from the current personal care provider or begin receiving services from the personal care provider applicant. The enrollee must also be fully aware of the option to select a different personal care provider. (Note: An agency that employs/subcontracts the caregiver with the permissive exclusion **cannot** be responsible for also completing the acknowledgement Form with the beneficiary as it is a **conflict of interest**.)

    a. When meeting with the enrollee, the care coordinator must bring an acknowledgement form (described below) for the enrollee to make a personal choice selection if he or she decides to receive services from the provider or applicant with a permissive exclusion. The care coordinator should also have a list of other eligible providers prepared in case the enrollee does not want to receive services from the excluded provider or applicant.

    b. If the criminal history screening consent form allows for re-disclosure of the findings, the care coordinator will give the enrollee a copy of the background check and will inform the enrollee of the convictions warranting the permissive exclusion.

    c. The provider or applicant with the permissive exclusion must not be allowed to participate in the discussion with the enrollee.

2. If the enrollee decides to receive care from a provider or applicant with a permissive exclusion through a personal choice selection, the care coordinator will help the enrollee complete the request.

a. The enrollee will sign an acknowledgement form stating that he or she is aware of the convictions related to the exclusion and still wants to receive personal care services from the provider or applicant.

b. The care coordinator will sign the acknowledgement form ensuring the excluded provider or applicant was not involved in the discussion with the enrollee and that during the discussion the enrollee reviewed the background check and was fully informed of the option to select a different personal care provider.

3. If the enrollee **does not** want to receive services from the provider or applicant with a permissive exclusion, the care coordinator will help the enrollee select a different personal care provider.

a. The care coordinator should meet in-person with the enrollee and anyone else the enrollee would like to involve in decisions regarding the personal care provider. The excluded provider or applicant may not be included in this meeting even if requested by the enrollee. The care coordinator should prepare a list of eligible providers prior to the meeting so that the enrollee can be presented with multiple options for a new personal care provider.

b. The care coordinator will explain that the enrollee may select someone already approved to provide personal care services or may select a new applicant who must also go through the criminal history screening process before payment is approved.

c. The ICO care coordinator should contact the provider/applicant and advise them that a different provider has been selected.

2.10 Appendix 11: Request for Correction to Waiver Enrollment

When deficiencies with a waiver enrollment submission are identified by MDHHS communication may be initiated via the MDHHS-MHL-WAIVER@michigan.gov mailbox. MDHHS will request that any deficiencies in documentation be corrected and uploaded to the CHAMPS enrollment. ICOs may also utilize the waiver mailbox for any questions related to CHAMPS enrollment and required documentation.

2.11 Appendix 12: Detailed Encounter Timeliness Requirements

A. Encounter Timeliness Report Guidelines

Integrated Care Organizations (ICOs) must meet minimum volume requirements by submitting timely and complete encounter data by the 28th of the month.

Report parameters:

- For the timeliness requirement, MDHHS will consider all encounters where Medicaid paid at least $0.01 and all sub-capitated encounters with a Claim Adjustment Reason Code (CARC) 24. Note that qualifying CARC 24 encounters could be paid by Medicaid or Medicare. Also note that these encounters may be found in both the 5776 and 5777 inbound encounter file types. Note that these encounters may be found in both the 5776 and 5777 inbound encounter file types. ICOs are still expected to submit encounters that are not sub-capitated where Medicaid did not pay (Medicare-only), although these encounters are not considered for the timeliness report.

MDHHS will generate timeliness reports monthly for each ICO showing at a minimum the number of paid/processed records submitted, the minimum number of records required to meet the timeliness requirement and whether the minimum has been met. Only unique TCNs will be counted. There are currently two ICO timeliness reports; one for Institutional, Professional and Dental encounters and the other for Pharmacy encounters. Reports are generated using the required criteria below:

Institutional, Professional, Dental Encounters	Pharmacy Encounters
• Encounter is accepted and active • Health Plan ID specific • Includes all members billed with a Medicaid ID • Paid date reported by Plan	• Encounter is accepted and active • Health Plan ID specific • Includes all Members billed with a Medicaid ID • Date of Payment (Check Date)

The Minimum Met column of the report will show a 'Yes' if minimum requirements were met and 'No' if the minimum was not met. A 'Yes' means that the plan receives a pass for the month. When plans do not meet the guidelines for timely encounter submission, they may request a review by sending an email to Encounter Processing (MDHHSEncounterData@michigan.gov), Encounter Quality (MDHHS-Encounter-Quality@michigan.gov) and Integrated Care (IntegratedCare@michigan.gov) mailboxes. The email should include the period for which they are requesting a review and why they deserve a 'Pass'.

Requests for a 'Pass' on timeliness will be reviewed by a committee with one or more members from the Integrated Care Division, Managed Care System Operations and Actuarial. If a 'Fail' on the timeliness report was the State's fault, either the failure was caused by technical issues during the encounter adjudication process or requests for assistance from the health plan were not responded to in five business days, the committee will issue a 'Pass'.

The health plan is expected to email all mailbox groups (Encounter Processing, Encounter Quality and Integrated Care) when requesting assistance and follow-up on unanswered emails. The health plan should also allow for a reasonable window before the timeliness deadline to request assistance. Please follow up at least 48 hours before the report deadline.

B. Administrative Specifications

Denominator: 1.5
Numerator: Plan-wide per member per month (PMPM) non-pharmacy service line average x total enrollment 2 months prior to the measurement month.

Algorithm to determine minimum volume:

- Plan-wide per member per month (PMPM) non-pharmacy service line average x total enrollment 2 months prior to the measurement month / 1.5
- The plan-wide PMPM average will be calculated annually based on a prior fiscal year. PMPM average = all plan total non-pharmacy service lines / annual plan-wide member months

C. Process

Plans submit files via the State File Transfer Site (FTS). To facilitate the processing of files, it is suggested that ICOs:

- Submit files at least a week in advance to ensure files will be completely processed by the 28th
- Decrease file size by submitting more frequently and keep file size to less than 50,000 transactions (maximum is 10 batches of 5,000 each)

2.12 Appendix 13: Oral Appeal Acknowledgment Template

Notice of Receipt of Oral Appeal
<Health plan/PIHP name>

Important: We are sending you this notice because you told us that you wanted us to review a decision we made to deny, suspend, or reduce a service to you. Your request is considered an appeal. This notice explains the next steps in the appeal process.

Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This notice is in response to an appeal that we received on <date received>.

Type of Service Subject to Notice: ☐ **Medicare** ☐ **Medicaid** ☐ **Medicare/Medicaid Overlap Service**

We got your appeal

We understand that you want us to review our decision: <decision being appealed>

You want us to review our decision because: <member's reason for appeal>

If any of this is not correct or if you do not want us to review our decision for any reason, you must let us know as soon as possible. You can call your Care Coordinator or Member Services at: <toll-free phone number> (TTY: <toll-free TTY number>), <days and hours of operation>.

If we have correctly described your appeal, we will begin processing it immediately. For our records, please sign the attached Acknowledgment form and send it back to us in the enclosed stamped, self-addressed envelope.

We received your appeal on <date received>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

What this means

We will make a decision by **<date received plus thirty (30) calendar days for medical service/item cases or date received plus seven (7) calendar days for a Medicare Part B drug case>**. We will mail you a letter telling you what our decision is and why we made that decision. If your appeal is for payment of a [*insert as applicable:* medical service/item *or* Part B drug *or* Medicaid drug] you've already received, we'll give you a written decision within **30 calendar days**. Our decision might take longer if you ask for an extension or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed.

[*Insert, if applicable*: Your appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving will continue while we review your appeal.]

We may contact you for more information or if we have questions. If you have any questions or more information to provide, please call <appeals-specific phone number/fax number>.

If you want someone to represent you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative at any time. If you want someone else to act for you, call us at: <phone number(s)> to learn how to name your representative. TTY users call <TTY number>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

Get help & more information

- **<Health plan name>**: If you need help or additional information about our decision and the appeal process, contact *[insert if applicable: your Care Coordinator or call]* Member Services at: <toll-free phone number> (TTY: <toll-free TTY number>), <days and hours of operation>. You can also visit our website at <URL>.
- **MI Health Link Ombudsman**: You can also contact the MI Health Link Ombudsman for help or more information. The staff can talk with you about how to make an appeal and what to expect during the appeal process. The MI Health Link Ombudsman is an independent program, and the services are free. Call 1-888-746-6456 (TTY: 711). The MI Health Link Ombudsman is available Monday through Friday, 8 a.m. to 5 p.m.
- **Medicare**: 1-800-MEDICARE (1-800-633-4227 or TTY: 877-486-2048), 24 hours a day, 7 days a week
- **Medicare Rights Center**: 1-800-333-4114, Monday through Friday
- **Elder Care Locator**: 1-800-677-1116 (Monday through Friday, 9 a.m. to 8 p.m.) or www.eldercare.acl.gov/Public/Index.aspx to find help in your community
- **Michigan Medicare Assistance Program (MMAP)**: 1-800-803-7174
- **Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line**: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet- based phone service).
- [*If applicable, insert other state or local aging/disability resources contact information.*]

[*Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

[*NorthCare insert:* NorthCare Network is a behavioral health plan that subcontracts with the Upper Peninsula Health Plan, which is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.]

[*Detroit Wayne Integrated Health Network insert:* Detroit Wayne Integrated Health Network is a behavioral health plan that subcontracts with Aetna Better Health of Michigan, AmeriHealth Michigan, MeridianComplete, HAP CareSource, and Molina Healthcare of Michigan, which are health plans that contract with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.]

[*Macomb County Community Mental Health insert:* Macomb County Community Mental Health is a behavioral health plan that subcontracts with HAP CareSource and Molina Healthcare of Michigan, which are health plans that contract with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees in Macomb County.]

[Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include: We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service. *[This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state.]*

OR

Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in Michigan and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.]

[*Plans that meet the 5% alternative language or Medicaid required language threshold insert:* This document is available for free in [*insert languages that meet the threshold as described the "Standards for required materials and content section" of the Marketing Guidance for Michigan Medicare-Medicaid Plans*].]

[*Plans must increase the font size and may use bold font to emphasize the following information.*] You can also get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.

2.13 Appendix 14 Personal Care Supplement Invoice

Invoice for Adult Foster Care/Homes for the Aged Personal Care Supplement

Billing Provider Information

1. Adult Foster Care (AFC) home or Home for the Aged (HFA) Organization Name or Caretaker First and Last Name (to whom the payment will be remitted):

2. Is the AFC/HFA home owned by a person or an organization?

3. What is the National Provider Identification (NPI) number? If not applicable, what is the Tax Identification Number (TIN)?

4. To what address should the payment be remitted? (Address Line, City, State, Zip):

Beneficiary Information

1. Beneficiary First and Last Name:

2. Beneficiary's Medicaid ID:

3. Beneficiary's Address (Address Line, City, State, Zip):

4. Beneficiary's Birthdate:

5. Beneficiary's Gender:

Rendered Services Information

1. This personal care supplement will cover dates from __/__/_____to___/__/_____.

2. Amount charged: $_____(Note: The current rate for one full month's service is $xxx.xx.)

Provider: By signing this claim, you are attesting that you and/or your organization rendered personal care services to the above beneficiary in the specified time frame, and you believe the beneficiary to be eligible for the personal care supplement.

Provider Signature: _____

Additional Information for Integrated Care Organizations

about the Invoice for Adult Foster Care/Homes for the Aged Personal Care Supplement

ICOs will be required to submit the information collected in this application to MDHHS via encounter data using an 837 format.

You may find the additional information useful; however, it may need to be additionally tailored to meet your organization's specific needs.

2.14 Appendix 15 COVID-19 Related Time Limited Policy

1. Temporary Premium Pay*** for Direct Care Workers

See L 20-28; L 20-42; L 20-67; L 21-02; L 21-30*; L 21-60**; L21-76***L22-10

Effective April 1, 2020, through September 30, 2021, in response to the COVID-19 state of emergency, a temporary hourly wage increase (referred to as "Premium Pay") will be applied to payment for direct care workers providing the following services:

Program Name	Services	Related HCPCS Codes
MI Health Link	Expanded Community Living Supports, Personal Care, Respite, Adult Day Program**	H2015, H2016, S5150, S5151, T1019, S5100, S5101, S5102

The temporary Premium Pay for services provided in April-December 2020 is intended to cover a $2.00* per hour increase in direct care worker wages, along with a $.24* per hour increase for agencies to cover their additional costs associated with implementing this increase. These amounts are to be paid in addition to the wage the direct care worker was earning since March 1, 2020 and recorded separately from base pay. The $2.00* per hour Premium Pay must be applied entirely to direct care worker wages. The $2.00* and $.24* per hour amounts may be implemented by an equivalent as divided per billing unit. One example of "an equivalent as divided per billing unit" is, for programs billing in 15-minute increments, the payment would be $.50* per 15-minute unit for the direct care worker, and $.06* per 15-minute unit for the additional agency cost.

For program participants receiving services through a self-determination arrangement under the MI Health Link program, direct care workers must receive this Premium Pay for the hours or billing units worked in between April 1, 2020, and February 28, 2021. The Fiscal Intermediary, or agency (for Agency with Choice), must receive $.24* per hour for related taxes. The "equivalent as divided per billing unit" described above applies.

All premium payments are subject to audit and potential recoupment. Providers should retain documentation that supports the distribution to direct care workers and that payments were made in accordance with the requirements.

Direct care workers should still follow the guidance issued in March titled "Actions for Caregivers of Older Adults During COVID-19" along with the FAQ document "Actions for Caregivers for Older Adults Addendum Frequently Asked Questions". These documents describe recommendations for in-home direct care workers and methods to assure a face-to-face visit is needed. These documents can be found at: https://www.michigan.gov/coronavirus/ and go to Resources, then For Health Professionals.
*Premium Pay rates for March 1, 2021-September 30, 2021, were increased to $2.25 in Direct Care Worker wages and $.0.27 per hour for agencies. See L 21-30 for details. Premium Pay rates for October 1, 2021-September 30, 2022, were increased to $2.35 in Direct Care

Worker wages and $0.29 per hour for agencies. See L-21-76

**Addition of Adult Day Program effective March 1, 2021-9/30/21. See L 21-60

*** The wage increase covering the period of 10/1/2021-09/30/2022 is referred to as 'FY 2022 Provider Pay Increase' versus 'Premium Pay'. The increase must still be recorded separately from base pay and is subject to audit and potential recoupment. See L 21-76

June 21, 2021, MDHHS released additional premium pay guidance for direct care workers employed by Michigan licensed adult foster care (AFC) or homes for the aged (HFA).

See L 21-39

Program Name	Services	Related HCPCS Codes
MI Health Link	Expanded Community Living Supports, Respite	H2015, H2016, S5150, S5151

Direct care worker premium payments for the aforementioned programs must be coordinated with MDHHS to avoid duplicative payment. On a monthly basis, program entities (MI Choice Waiver agencies, Prepaid Inpatient Health Plans, and MI Health Link Integrated Care Organizations) will receive a list from MDHHS that will include all AFCs and HFAs that received the Medicaid personal care supplemental payment by MDHHS the previous month for at least one Medicaid beneficiary residing in those settings. For those settings on the list from MDHHS, the program entity must not pay the direct care worker premium pay. It will be up to those settings to request premium payment directly from MDHHS. The AFCs and HFAs will be informed of that process by MDHHS. The payment from MDHHS will include $2.25 per hour plus FICA payroll tax.

There may be some Medicaid beneficiaries residing in licensed AFC or HFA settings **not included on the list of settings from MDHHS and receiving services indicated above**. For these beneficiaries, as applicable, the program entities indicated above must pay these settings the premium pay for direct care workers providing services. The premium payment is $2.25 per hour applied directly to direct care worker wages and recorded separately from base pay. The $2.25 per hour amounts may be implemented by an equivalent as divided per billing unit. One example of "an equivalent as divided per billing unit" is, for programs billing in 15- minute increments, the payment would be $0.56 per 15-minute unit for the direct care worker. An additional $0.27 per hour or billing unit equivalent must be paid to the AFC or HFA to cover employer taxes associated with implementing this increase.

All Premium Payments are subject to audit and potential recoupment. Providers should retain documentation that supports the distribution to direct care workers and that payments were made in accordance with the requirements in this letter.

Effective CY 2022 the Direct Care Worker increase will be paid through a directed payment as approved by CMS through the Section 438.6(c) preprint process. See Section 33 of the MOS for details.

L22-10 was released March 15, 2022, to provide clarification for calculating the pay increase when a worker was not employed or an agency was not in existence in March 2020.

1. Appendix K: Temporary Amendments To 1915c Waiver

APPENDIX K: Emergency Preparedness and Response*

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: **Michigan**

B. Waiver Title: MI Health Link Home and Community Based Services Waiver

C. Control Number:

MI.1126.01.01

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
○	**Natural Disaster**

○	**National Security Emergency**
○	**Environmental**
	Other (specify):

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals

at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: _03/01/2020_____Anticipated End Date: 02/28/2021*;

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___ Access and Eligibility:

i. ____ **Temporarily increase the cost limits for entry into the waiver.**

[Provide explanation of changes and specify the temporary cost limit.]

ii. ___ **Temporarily modify additional targeting criteria.**

[Explanation of changes]

b. _X_ Services

i. **_X_ Temporarily modify service scope or coverage.**

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. **___X Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.**

[Explanation of changes]

- Home Delivered Meals

-Temporarily suspend limitations on who may receive a home delivered meal so that any waiver enrollee in need may receive home delivered meals during this emergency. Allow restaurants and meal delivery kits (e.g. Hello Fresh) as home delivered meals.

- Private Duty Nursing (PDN)
  - Suspend 16 hour limit on Private Duty Nursing (PDN) when the need for exceeding 16 hours stems from impacts related to COVID-19
- ECLS
  -Temporarily expand the expanded community living supports (ECLS) definition to include transportation on behalf of the participant to allow vulnerable individuals to practice social distancing or self-isolation per CDC guidance. Plans may use this service to authorize MI Health Link HCBS funds to reimburse individuals to run errands for participants when the participant does not accompany the driver of the vehicle to allow vulnerable participants to practice social distancing or self-isolation during the COVID-19 emergency. The purpose of expanding the ECLS service is for the participant to gain access to the community and to allow others to obtain items required for the participant to avoid unnecessary exposure to COVID-19 as needed.
  -Temporarily allow for remote service delivery. Please refer to Attachment A.
- Adaptive Medical Equipment and Supplies
  - Add personal protective equipment (PPE) related to impacts from COVID-19.

iii. ___**Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).**

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. __**Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:**

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v. ___ **Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver).** [Explanation of changes]

c. ___ **Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver**. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d. ___ **Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).**

i. __X_ **Temporarily modify provider qualifications.**

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

For Expanded Community Living Supports, temporarily relax provider training requirements during the pandemic. Providers would still be required to be aged 18 or older and have training in universal precautions. Additionally, they would need to be able to competently perform the essential duties of the position and be able to effectively communicate with the participants they serve. They would also need to be trained on identifying and reporting on critical incidents.

This relaxation of provider qualifications is in effect during the state of emergency. All providers hired must fulfill all other normal provider qualification training as soon as they are able after the pandemic but not to exceed the end date of the Appendix K.

ii. ___ **Temporarily modify provider types.**

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. ___ **Temporarily modify licensure or other requirements for settings where waiver services are furnished.**

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. X_ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

Because of the recommendation for social distancing and self-isolation for the population served, MDHHS extends any level of care determinations that will expire during the effective period of this appendix by up to one year past the original due date, or for the duration of the approved Appendix K. Additionally, new evaluations may be completed telephonically, via telehealth, or using video conferencing commonly available on smart phones in accordance with HIPAA.**

f.___X_ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

MDHHS will temporarily provide the flexibility to adjust provider rates to account for increased risk factors associated with COVID-19. This flexibility will apply to authorized services billable to Expanded Community Living Supports and Respite (H2015, H2016, S5150, S5151) in which face to face contact is essential for beneficiary health and safety. The amount of the increase in payment rates to providers and the effective time periods (within the timeframes of this Appendix K) will be determined by MDHHS and paid to the ICOs for these populations. This rate increase will not exceed 50% of the currently approved rates.

g. _X_ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan

development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

Care coordinators may be allowed to complete person-centered service planning tasks telephonically, via telehealth, or using video conferencing commonly available on smart phones in accordance with HIPAA.

For individuals who are unable to receive the services on their person-centered service plan because of the social distancing recommendations, allow monthly monitoring of the individual

when services are furnished on a less than monthly basis in lieu of requiring the provision of at least one waiver service in addition to supports coordination. This includes individuals who cannot find a replacement caregiver when their usual caregiver is unable to deliver services as well as individuals who may normally attend an Adult Day Health service and that service is temporarily closed.

The state will ensure the person-centered service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible but no later than 30 days to ensure that the specific service is delineated accordingly to the date it began to be received. The care coordinator must submit the request for additional supports/services no later than 30 days from the date the service begins.

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m._X_ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

- Delay provider monitoring deadlines for those providers scheduled for monitoring activities during the 1st and 2nd quarter of 2020 to 12/31/2020.
- The timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.

Appendix K Addendum: COVID-19 Pandemic Response

1. Regulations

a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic. Suspend on-site setting surveys.

b. And to implement the following measures designed to limit the spread of COVID-19:

1. Allow providers in these settings to isolate individuals with COVID-19 symptoms from other residents.
2. Allow providers in these settings to limit community participation activities for residents who are at high risk of severe illness.
3. Allow providers to implement social distancing measures as feasible, such as reducing large gatherings, altering meal schedules to reduce mixing, and limiting programs with external staff.

2.

a. an electronic method of service delivery (e.g, telephonic) allowing services to continue to be provided remotely in the home setting for:

i. ☒ Case management
ii. ☒ Personal care services that only require verbal cueing
iii. ☐ In-home habilitation
iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
v. ☐ Other *[Describe]:*

b. Home-delivered meals
c. Medical supplies, equipment and appliances (over and above that which is in the state plan)
d. Assistive Technology

3. f Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qual ed

entity.

a. ☒ Current safeguards authorized in the approved waiver will apply to these entities.
b. ☐ Additional safeguards listed below will apply to these entities.

4. r Qualifications

a. and parents of minor children to provide ECLS.
b. family member to be paid to render services to an individual.
c. r practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5.

a. extension for reassessments and reevaluations for up to one year past the due date.
b. e option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
c. approval/authorization elements approved in waiver.
d. sment requirements

e. electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

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

First Name:	Jacqueline
Last Name	Coleman
Title:	Waiver Specialist
Agency:	MSA, MDHHS
Address 1:	P.O. Box 30479
Address 2:	400 S Pine, 7th Floor
City	Lansing

State	MI
Zip Code	48909-7979
Telephone:	517-248-1190

E-mail	colemanj@michigan.gov
Fax Number	517-241-5112

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

Signature:

State Medicaid Director or Designee

Date:	**June 18, 2020**

First Name:	Kate
Last Name	Massey

Title:	Medicaid Director
Agency:	MSA, MDHHS
Address 1:	P.O. Box 30479
Address 2:	400 S Pine, 7th Floor
City	Lansing
State	MI
Zip Code	48909-7979
Telephone:	517-241-7882
E-mail	Masseyk4@michigan.gov
Fax Number	517-335-5007

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. 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 Specification	
Service Title:	Adaptive Medical Equipment and Supplies
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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.

Personal protection equipment related to impacts from COVID-19.

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.				
Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Retail stores
				Enrolled Medicaid or Medicare DME Providers
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian
Provider Qualifications (*provide the following information for each type of provider)*:				
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*	

Retail Store	N/A	N/A	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.
Enrolled Medicaid or Medicare DME Provider	N/	N/A	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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Retail Store	ICO	Prior to initial delivery of service and annually thereafter

Enrolled Medicaid or Medicare DME Provider	ICO	Prior to initial delivery of service and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	Expanded Community Living Supports (ECLS)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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, money management, 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.

If through assessment it is found to be appropriate, ECLS (cueing/prompting) Services may be provided remotely by providers when travel to the waiver enrollee is not possible due to COVID-19 infection. Approval of remote support must be reflected on the individual integrated care and support plan.

Allow transportation on behalf of the participant to allow vulnerable individuals to practice social distancing or and to allow others to obtain items required for the participant to avoid unnecessary exposure to COVID self-isolation per CDC guidance.

Plans may use this service to authorize MI Health Link HCBS funds to reimburse individuals (ECLS providers) to run errands for participants when the participant does not accompany the driver of the vehicle to allow vulnerable participants to practice social distancing or self-isolation during the COVID-19 emergency. The purpose of expanding the ECLS service is for the participant to gain access to the community as needed.

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.
Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals chosen by the enrollee		Homecare Agency	

Specify whether the service may be provided by *(check each that applies):*		Legally Responsible Person		Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual	N/A	N/A	1. Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, 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 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. Must be deemed capable of performing the required tasks by ICO. • Training required for direct care workers (ECLS) will be limited to universal precautions, competency for completing required tasks, reporting and identifying abuse and neglect, and the ability to effectively communicate with the individual. Program-specific training requirements would be completed as soon as possible once the effective period ends

Agency	N/A	N/A	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 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. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable. • Training required for direct care workers (ECLS) will be limited to universal precautions, competency for completing required tasks, reporting and identifying abuse and neglect, and the ability to effectively communicate with the individual.

			Program-specific training requirements would be completed as soon as possible once the effective period ends.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	ICO	Prior to initial delivery of services and annually thereafter
Agency	ICO	Prior to initial delivery of services and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	Home Delivered Meals
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
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. When providing more than a two-week supply of meals in one delivery, the service must not exceed two meals per day. Additionally, when providing more than a two-week supply of meals in one delivery, meals may be a combination of fresh, frozen, and shelf stable meals for the first two weeks. Meals delivered for days after the first two-weeks must be frozen or shelf stable and the beneficiary must have available and appropriate storage for the meals.

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:

During the effectiveness of this Appendix, MDHHS will lift all restrictions on who may receive a home delivered meal. This would make home delivered meals an option for any person enrolled in the MI Health Link waiver during this crisis. This also allows meal deliveries to be left at the door to avoid unnecessary in-person contacts.

Provider Specifications				
Provider Category(s)	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Delivered Meal Providers

(check one or both):		Licensed restaurants with delivery service
		Meal Kit Delivery Service Providers (Hello Fresh, Blue Apron, Home Chef, etc.)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Delivered Meal Provider	Health Code Standards (PA 368 of 1978)	N/A	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.

Licensed Restaurants with delivery service	Health Code Standards (PA 368 of 1978)	N/A	1. The provider must deliver food at safe temperatures. Meals that are delivered in a frozen state must include directions on how to reheat the meals to a safe temperature. Delivery costs are included in the total price of the meal.
Meal Kit Delivery Services	N/A	N/A	1. The provider must deliver food at safe temperatures. Meals that are delivered in a frozen state must include directions on how to reheat the meals to a safe temperature. 2. Delivery costs are included in the total price of the meal. The participant or someone in the household must be able to read directions to prepare the meals as instructed.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meal Provider	ICO	Prior to the delivery of services and annually thereafter.
Licensed restaurants that deliver	ICO	Prior to the delivery of services and annually thereafter.
Meal Kit Delivery Services	ICO	Prior to the delivery of services and annually thereafter.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	Private Duty Nursing
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
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, 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.

- Suspend 16-hour limit on Private Duty Nursing (PDN) when the need for exceeding 16 hours stems from impacts related to COVID-19

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.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)		Private Duty Nursing Agency, Home care Agency	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)	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.	N/A	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.
Private Duty Nursing Agency, Home care Agency	Nursing MCL 333.17201 … 333.17242 This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under		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.

	the supervision of an RN.		3. This service may include medication administration as defined under the referenced statutes.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Private Duty Nurse (Licensed Practical Nurse or Registered Nurse)	ICO	Prior to initial delivery of services and annually thereafter
Private Duty Nursing Agency, Home care Agency	ICO	Prior to initial delivery of services and annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E	X	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

* **Appendix K Amendment #1 was approved March 10, 2021: The purpose of this amendment is to extend the end date of the Appendix K to six months after the conclusion of the public health emergency. Though the state is requesting to extend the end date for the Appendix K amendment, the Department reserves the right to remove flexibilities that have been approved which are no longer deemed necessary. Providers and recipients will be notified in advance of any change to state policy/flexibility end dates contained in the Appendix K. Medicaid appeal rights will be made available to all waiver recipients and providers as applicable.**

**** Appendix K Amendment #2 was approved March 29, 2021: This amendment clarifies due dates of recertifications and allows for alternative methods of conducting the recertification assessments. Because of the recommendation for social distancing and self-isolation for the population served, MDHHS extends any level of care determinations that will expire during the effective period of this appendix for 12 months beyond the due date of the recertification.**

Additionally, new evaluations and re-evaluations that must be conducted may be completed telephonically, via telehealth, or using video conferencing commonly available on smart phones in accordance with HIPAA.

*****Appendix K Amendment #3 was approved May 18, 2023: This additive amendment modifies The Level of Care Determination extensions will end on 5/11/2023. The flexibility to allow Level of Care Evaluations to be conducted virtually will end 5/11/2023. As of 5/12/2023 all initial Level of Care Evaluations must be conducted in person. All HCBS regulation flexibilities in the Addendum section of this Appendix K also are terminated effective 6/12/23. All other flexibilities remain in place until the end date six months after the conclusion of the public health emergency 11/12/23.**

Because of the recommendation for social distancing and self-isolation for the population served, MDHHS extends any level of care determinations that will expire during the effective period of this appendix for 12 months beyond the due date of the recertification. Additionally, new evaluations and re-evaluations that must be conducted may be completed telephonically, via telehealth, or using video conferencing commonly available on smart phones in accordance with HIPAA. The flexibilities described here will end May 11, 2023, consistent with the end of the Public Health Emergency.

4. Waiver Re-Certifications when beneficiary no longer eligible during COVID Public Health Emergency

1.) Plan submits timely and clearly documents in their records when the bene does not meet criteria and that they cannot disenroll due to the Public Health Emergency (PHE)/COVID. Note: following 3-9-21 ICOs should also follow LOCD guidance when re-evaluations indicate member no longer meets an eligible door (see LOCD guidance below).

a. MDHHS will provide additional guidance to ICOs specific to these cases when the PHE has ended.

5. LOCD Guidance

1.) LOCD guidance on extending all provider type LOCD end dates from the beginning of the public health emergency through February 2021 can be found in the following L letters:
L 20-19, L 20-43, L 20-59, L 20-70

2.) March 9, 2021, MDHHS released additional LOCD guidance by program type.
HCBS including MI Health Link waiver guidance: L 21-18 Nursing Facility guidance: L 21-19

3.) June 17, 2021, MDHHS released additional LOCD guidance by program type.
HCBS including MI Health Link waiver guidance: L-21-36 Nursing Facility guidance: L 21-37

4.) August 11, 2021, MDHHS released additional LOCD guidance for Nursing Facilities

Nursing Facility: L 21-57

5.) October 18, 2021, MDHHS released additional LOCD guidance

All programs: L 21-66

2.15 Appendix 16 Learning Management System Contract Crosswalk

MDHHS Michigan Department of Health & Human Services
MI Health Link

Training Contract Requirements Crosswalk

Annual training to be completed between 1/1-12/31 of each Calendar Year (CY) starting in 2022.

Table 1

Name of Course	Frequency of Completion	Contract Requirements	Required for
All courses	Within 30 days of hire.	2.5.3.1.1. 2.5.3.1.4.3. 2.7.6.7.	Care Coordinators LTSS coordinators
Person-centered Planning (PCP)	Within 30 days of hire, and annually thereafter.	2.5.3.1.2. 2.5.3.1.4.1. 2.5.4.7.2. 2.7.6.8.6	Care coordinators LTSS coordinators Providers
Introduction to MI Health Link	Within 30 days of hire.	2.5.3.1.4.3. 2.7.6.1. 2.7.6.2. 2.9.1.6	Care coordinators LTSS coordinators Providers Enrollee service representatives
Assessments	Within 30 days of hire.	2.5.3.1.4.3. 2.6.6.4.	Care coordinators LTSS coordinators
Care Coordination	Within 30 days of hire, and annually thereafter.	2.5.3.1.2. 2.5.4.7.2. 2.7.6.2. 2.7.6.8.6	Care coordinators LTSS coordinators Providers
Critical Incidents	Within 30 days of hire, and annually thereafter.	2.5.3.1.2. 2.5.4.7.5. 2.7.6.7.5.3.	Care coordinators LTSS coordinator Providers
Advanced Directives	Within 30 days of hire.	2.5.3.1.4.3. 2.7.6.7. 2.7.6.7.5.1.	Care coordinators LTSS coordinators Nursing facility providers

Table 1*			
Name of Course	**Frequency of Completion**	**Contract Requirements**	**Required for**
Cultural Competency	Within 30 days of hire.	2.5.3.1.2. 2.5.4.7.3. 2.7.6.7.9. 2.9.1.12	Care coordinators LTSS coordinators Providers Enrollee service representatives
Disability Awareness	Within 30 days of hire.	2.5.3.1.2. 2.7.6.7. 2.7.6.7.4. 2.7.6.8. 2.9.1.12	Care coordinators LTSS coordinators Providers Enrollee service representatives
Self-Determination	Within 30 days of hire.	2.5.3.1.4.2. 2.5.4.7.2. 2.7.6.8.	Care coordinators LTSS coordinators Providers
Behavioral Health Consent	Within 30 days of hire.	2.5.3.1.4.3.	Care coordinators LTSS coordinators Providers Enrollee service representatives
Disability, Functional Needs, and Emergency Preparedness (Available in LMS 1/6/21)	Within 30 days of hire.	2.5.3.1.4.3.	Care coordinators LTSS coordinators

* Table 1 should be used to determine who within your organization and contracted entities is required to complete LMS training. The trainings indicated in the table as needing to be completed within 30 days of hire do not need to be repeated if the new hire has evidence of completing the LMS course through previous employment. Contract training requirements listed in Table 2 may require additional training beyond what is available in the Learning Management System (LMS). It is the ICO's responsibility to ensure all training requirements are met.

Table 2*	
2.5.3.1.1.	ICO Care Coordinators must have the experience, qualifications and training including MDHHS required training appropriate to the needs of the Enrollee.
2.5.3.1.2.	ICO Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, substance use disorder, physical and developmental disabilities, issues related to accessing and using durable medical equipment as appropriate, available community services and public benefits, quality ratings and information about available options such as nursing facilities, applicable legal non-discrimination requirements such as the ADA, person centered planning, cultural competency, and elder abuse and neglect.
2.5.3.1.4.1.	The ICO Care Coordinator will participate in train-the-trainer Person-Centered Planning educational opportunities offered by MDHHS. The ICO will be responsible for training ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDHHS and ICO trainings as required.
2.5.3.1.4.2.	The ICO Care Coordinators will participate in train-the-trainer Self-Determination education opportunities offered by MDHHS. The ICO will be responsible for training ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDHHS and ICO trainings as required.
2.5.3.1.4.3.	The ICO will participate, train and report on any other training required or offered by MDHHS or its designee.
2.5.4.7.2.	The LTSS Supports Coordinator must have completed a person-centered planning and Self-Determination training.
2.5.4.7.3.	The LTSS Supports Coordinator must be culturally competent.

Table 2*	
2.5.4.7.4.	The LTSS Supports Coordinator must be able to provide information regarding the quality ratings and licensure status, if applicable, of available options;
2.5.4.7.5.	The LTSS Supports Coordinator must be knowledgeable about risk factors and indicators of and resources to respond to abuse and neglect;
2.5.4.7.6.	The LTSS Supports Coordinator must be familiar with applicable long term care facility licensing requirements and resources such as the long-term care ombudsman program;
2.6.6.4.	Level II Assessments will be conducted by professionally knowledgeable and trained LTSS Supports Coordinators or PIHP Supports Coordinators or behavioral health case managers, who have experience working with the population;
2.7.5.5.	Except as otherwise required or authorized by CMS, MDHHS, or by operation of law, the ICO shall ensure that providers receive (30) calendar days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect;
2.7.6.1.	Prior to any Enrollment of Enrollees under this Contract and thereafter, the ICO shall conduct network provider education regarding the ICO's policies and procedures as well as the Demonstration.
2.7.6.2.	The ICO must educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;
2.7.6.3.	The ICO must inform its Provider Network about its policies and procedures, especially regarding in and out-of-network referrals;
2.7.6.4.	The ICO must inform its Provider Network about its service delivery model and Covered Services, flexible benefits, excluded services (carved-out) and, policies, procedures, and any modifications to these items;
2.7.6.5.	The ICO must inform its Provider Network about the procedures and timeframes for Enrollee Grievances and Enrollee Appeals, per 42 C.F.R. § 438.414;

Table 2*	
2.7.6.6.	The ICO must inform its Provider Network about its quality improvement efforts and the providers' role in such a program;
2.7.6.7.	The ICO must ensure that all network providers receive proper education and training regarding the Demonstration to comply with this Contract and all applicable federal and State requirements. The ICO shall offer educational and training programs that cover topics or issues including, but not limited to, the following:
2.7.6.7.1.	Eligibility standards, eligibility verification, and benefits;
2.7.6.7.2.	The role of MDHHS (or its authorized agent) regarding Enrollment and disenrollment;
2.7.6.7.3.	Special needs of Enrollees that may affect access to and delivery of services, to include, at a minimum, transportation needs;
2.7.6.7.4.	ADA compliance, accessibility and accommodations;
2.7.6.7.5.	The rights and responsibilities pertaining to 2.7.6.7.5.1. Advance Directives 2.7.6.7.5.2. Grievance and Appeals procedures; 2.7.6.7.5.3. Procedures for identifying, preventing and reporting Fraud, waste, neglect, abuse, exploitation, and critical incidents;
2.7.6.7.6.	References to Medicaid and Medicare manuals, memoranda, and other related documents;
2.7.6.7.7.	Payment policies and procedures including information on improper billing;
2.7.6.7.8.	PCP training on identification of and coordination of LTSS and Behavioral Health services;
2.7.6.7.9	Cultural competencies
2.7.6.7.10.	Person-Centered Planning Processes taking into consideration the specific needs of subpopulations of Enrollees;
2.7.6.7.11.	Billing instructions which are in compliance with the Demonstration Encounter Data submission requirements; and,

Table 2	
2.7.6.7.12.	Marketing practice guidelines and the responsibility of the provider when representing the ICO.
2.7.6.8	The ICO must train or assure training of its medical, behavioral, and LTSS providers on disability literacy, including, but not limited to the following information: 2.7.6.8.1. Various types of chronic conditions prevalent within the target population; 2.7.6.8.2. Awareness of personal prejudices; 2.7.6.8.3. Legal obligations to comply with the ADA requirements; 2.7.6.8.4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs; 2.7.6.8.5. Types of barriers encountered by the target population; 2.7.6.8.6. Training on the Person-Centered Planning Process and Self-Determination, the social model of disability, the Independent Living Philosophy, and the recovery model; 2.7.6.8.7. Use of evidence-based practices and specific levels of quality outcomes; and 2.7.6.8.8. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.

Table 2*	
2.9.1.1.	The ICO must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d).
2.9.1.2	ESRs must be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees
2.9.1.3.	ESRs must be trained in the use of TTY/TDD, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats as described in Section 2.8.1.6.3.6.
2.9.1.6.	ESRs must be knowledgeable about Michigan Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;
2.9.1.7.	ESRs must be knowledgeable about PIHP services and enrollee service lines including the PIHP twenty-four (24) hour crisis line and transfer or refer callers appropriately
2.9.1.12.	ESRs must demonstrate sensitivity to culture, including disability culture, the Independent Living Philosophy, and Person-Centered Planning;
2.9.2.1.2.	ESRs must be appropriately trained and qualified health professionals who, according to HIPAA laws, access the Enrollee's issues and provide and appropriate course of action (i.e. medical advice, direct Enrollee to an appropriate care setting, etc.)
2.13.3.8.	Maintain sufficient and qualified staff employed by the ICO to manage the QI activities required under the Contract and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include the following individuals:

* Table 1 should be used to determine who within your organization and contracted entities is required to complete LMS training. Contract training requirements listed in Table 2 may require additional training beyond what is available in the Learning Management System (LMS). It is the ICO's responsibility to ensure all training requirements are met.

2.16 Appendix 17 Person-Centered Planning Practice Guideline

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES INTEGRATED CARE DIVISION

PERSON- CENTERED PLANNING PRACTICE GUIDELINE

What are the Values and Principles that Guide the Person-Centered Planning (PCP) Process?

PCP is an individualized process designed to respond to the unique needs and desires of every individual. The following values and principles guide the PCP process whenever it is used.

a. Every individual is presumed competent to direct the planning process, achieve the individual's goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the individual's ability to make choices.
b. Every individual has strengths, can express preferences, and can make choices. The PCP approach identifies the individual's strengths, goals, choices, medical and support needs, and desired outcomes. In order to be strength-based, the positive attributes of the individual are documented and used as the foundation for building the individual's goals and plans for community life as well as strategies or interventions used to support the individual's success.
c. The individual's choices and preferences are honored. Choices may include the family and friends involved in the individual's life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships, friendships, and transportation. Individual choice must be used to develop goals and to meet the individual's needs and preferences for supports and services and how they are provided.
d. The individual's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the individual to implement the individual's choices or preferences over time.
e. Every individual contributes to their own community and has the right to choose how supports and services enable the individual to meaningfully participate and contribute to their community.
f. Through the PCP process, an individual maximizes independence, creates connections, and works towards achieving the individual's chosen outcomes.
g. An individual's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices, and other things chosen by the individual. Linguistic needs, including American Sign Language (ASL) interpretation, are also recognized, valued, and accommodated.

What are the Essential Elements of the PCP Process?

The following elements are essential to the successful use of the PCP process with an individual and those invited by the individual to participate.

a. **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.
b. **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The individual's goals, interests, desires, and choices are

identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the individual's needs or choices, rather than viewed as an annual event.

c. **Outcome-Based**. The individual identifies outcomes to achieve in pursuing the individual's goals. The way that progress is measured toward achievement of outcomes is identified.
d. **Information, Support, and Accommodations**. As needed, the individual receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the care plan. Support and accommodations to assist the individual to participate in the process are provided. The individual is offered information on the full range of services available in an easy-to-understand format.
e. **Independent Facilitation.** Every individual has the information and support to choose an independent facilitator to assist the individual in the planning process.
f. **Pre-Planning.** The purpose of pre-planning is for the individual to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Every individual must use pre-planning to ensure successful PCP. Pre-planning, individualized for the individual's needs, is used anytime the PCP process is used.

   The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):

   1. When and where the meeting will be held.
   2. Who will be invited, including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to deal with them as to what will be discussed and not discussed.
   3. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

g. **Wellness and Well-Being.** Issues of wellness, well-being, health, and primary care coordination support needed for the individual to live the way they want to live are discussed and plans to address them are developed. Individuals are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, and eating candy or other sweets). If the individual chooses, issues of wellness and well-being can be addressed outside of the PCP meeting. PCP highlights personal responsibility, including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the individual's right to assume some degree of personal risk. The plan must assure the health and safety of the individual. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).
h. **Participation of Allies.** Through the pre-planning process, the individual selects allies (friends, family members, and others) to support the individual through the PCP process. Preplanning and planning help the individual explore who is currently in the individual's life and what needs to be done to cultivate and strengthen desired relationship

2.17 Appendix 18 We Treat Hep C Coordination Plan for MI Health Link

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

MEMORANDUM

DATE: August 16th, 2021

TO: Integrated Care Organizations (ICO)

FROM: Medical Services Administration (MSA)

SUBJECT: We Treat Hep C Care Coordination Plan for MI Health Link

MDHHS has announced a public health campaign called *We Treat Hep C*, aimed at eliminating Hepatitis C Virus (HCV) in Michigan. New treatments can cure patients of HCV in as little as 8 weeks through oral medications taken once per day. The We Treat Hep C initiative involves increasing the number of people who are tested for HCV, increasing the number of providers who treat HCV, and expanding access to HCV curative treatments. According to statistics from the Centers for Disease Control (CDC), persons born between 1945 and 1965 make up 36% of newly reported chronic HCV.[1] Therefore, ICOs will play a central role in testing members for HCV and ensuring those who test positive have access to treatment. This memo provides background on HCV, the We Treat Hep C campaign, and outlines the expectations for ICOs around care coordination.

Hepatitis C

HCV is a liver infection caused by the hepatitis C virus. It is spread through contact with blood from an infected person. The most common way HCV is transmitted is through sharing needles, syringes or other equipment used to prepare and inject drugs. HCV is the most common bloodborne infection in the United States. For some people, HCV is a short-term illness that resolves spontaneously, but for most people who become infected with HCV, it becomes a chronic infection. Chronic HCV can result in serious, even life-threatening health problems like cirrhosis and liver cancer.

People with chronic HCV often have no symptoms and do not feel sick. When symptoms appear, they often are a sign of advanced liver disease. Approximately 115,000 people in Michigan are known to have HCV, though estimates suggest that approximately half of those living with HCV are undiagnosed, which means the number of infected people may be as high as 200,000.[2] The number of persons unknowingly living with undiagnosed HCV infection is why broad population-based HCV testing is important.

[1] https://www.cdc.gov/nchhstp/newsroom/2020/hepatitis-c-impacting-multiple-generations-press-release.html
[2] In 2019, approximately 115,000 persons were reported to the Michigan Data Surveillance System as living with HCV. Approximately 50% of persons living with HCV are unaware of their infection. Thomas, D.L. (2020), State of the Hepatitis C Virus Care Cascade. Clinical Liver Disease, 16: 8-11. https://doi.org/10.1002/cld.915

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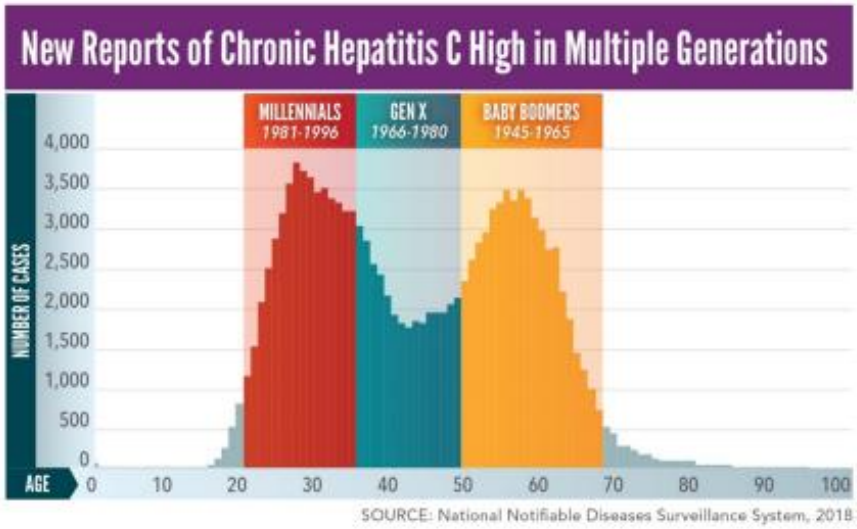
HCV in Persons Born Between 1945-1965

Michigan data shows the number of new chronic hepatitis C diagnoses in persons born between 1945 and 1965 is the largest of any other birth cohort. From 2005 to 2014, there were a total of 116,926 hospitalizations due to hepatitis C among those born between 1945 and 1965 – which is more than six times the number of HIV hospitalizations among this same population.[3]

The reason that people born from 1945–1965 have high rates of hepatitis C is not completely understood. Most persons in this age range are believed to have become infected in the 1960s through the 1980s, before HCV was well understood and when transmission may have been highest. Hepatitis C is primarily spread through contact with blood from an infected person. Persons born between 1945 and 1965 could have gotten infected from medical equipment or procedures before universal precautions and infection control procedures were adopted. Others could have gotten infected from contaminated blood and blood products before widespread screening virtually eliminated the virus from the blood supply by 1992. For these reasons, the prevalence of HCV is high among this age cohort.

Recommendations on HCV testing have historically targeted this high risk group. However, the opioid crisis shifted the course of the hepatitis C epidemic in less than a decade. New data show that chronic HCV impacts multiple generations, with millennials (most adults in their 20s and 30s) making up 36.5% of newly reported chronic HCV infections.[4]



Based on this changing landscape, in 2020 the CDC revised its guidelines to recommend universal HCV testing for all adults.

[3] Michigan.gov/hepatitis
[4] https://www.cdc.gov/nchhstp/newsroom/2020/hepatitis-c-impacting-multiple-generations.html

2

HCV Testing Recommendations

The CDC recommends that all adults ages 18 and older should be tested for HCV at least once in a lifetime.[5] In addition, the CDC recommends routine periodic testing for people with ongoing risk factors while risk factors persist, such as people who currently inject drugs and share needles, syringes, or other drug preparation equipment. For more information, see Testing Recommendations for Hepatitis C Virus Infection.

HCV Treatment

Up until a few years ago, HCV treatment required weekly injections and oral medications that many affected people could not take because of other health problems or side effects. In recent years, new drugs called Direct-Acting Antivirals (DAA) – were developed to treat hepatitis C. DAAs are oral medications that can cure the disease when taken every day for several weeks, and have few side effects or contraindications. With success rates of over 95%, these drugs have the potential to virtually eliminate the disease. However, the extraordinarily high prices associated with these drugs has prevented their broader use in the population. More recently, competition in the drug class has driven prices down considerably.

We Treat Hep C

Last year, MDHHS worked with providers, academic institutions, patient advocacy groups, local health departments, and state government officials to develop a comprehensive plan to eliminate HCV in Michigan. This report, called *Michigan's State Plan on Eliminating Hepatitis C*, outlined an action plan that included data strategy, reducing stigma, education and training for providers, and expanding access to HCV curative treatments. On World Hepatitis Day, July 28, 2020, MDHHS launched the *We Treat Hep C* initiative to implement this action plan.

Through the We Treat Hep C initiative, MDHHS aims to eliminate HCV in Michigan. This will involve:

- Expanding access to HCV curative treatments
- Testing all adult beneficiaries for HCV, per CDC recommendations
- Prescribing treatment for those with a confirmed HCV diagnosis

Expanding Access to Treatment

In FY16 the Michigan Legislature approved an appropriation transfer which provided funding to cover specialty HCV products for Medicaid and Healthy Michigan Plan enrollees. MDHHS has historically limited access to DAAs using prior authorization (PA) criteria that included liver disease severity, documentation of sobriety, and requirement that it must be prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist. In FY17 the Legislature approved an additional appropriation transfer to expand coverage.

MDHHS was the defendant in a class action lawsuit on the grounds that the HCV coverage criteria was overly restrictive. MDHHS reached a settlement with the plaintiffs where the illness severity restriction was gradually removed over the course of two years. However, the sobriety and specialist requirements remained. MDHHS approved approximately 1800 PAs for DAAs each year, but we estimate that over 80% of the affected Medicaid population remains untreated.

[5] The CDC defines an HCV test to mean a blood draw to detect antibodies to HCV, which are indicative of HCV exposure. For persons that are reactive for HCV antibody, a subsequent test (that often can be run from the same specimen), can be run to detect HCV virus RNA in the blood to confirm presence of HCV Infection. See the CDC's Recommended Testing Sequence.

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To expand access to HCV treatment, MDHHS removed PA from the DAA MAVYRET® (glecaprevir/pibrentasvir) for the Medicaid and Healthy Michigan Plan programs. MAVYRET no longer requires PA when prescribed in accordance with Food and Drug Administration (FDA)-approved labeling. This includes removal of the requirement that HCV medications must be prescribed by a specialist. All providers who have prescriptive authority are now able to prescribe this treatment to their patients with HCV. Since MDHHS removed PA on MAVYRET on April 1, 2021, there has been an 80% increase in the number of beneficiaries who have received treatment.[6]

To align with the goal of We Treat Hep C to eliminate HCV in Michigan, ICOs should conduct outreach and consider PA removal for their Hep C drugs on future formularies. In addition, to promote medication adherence ICOs should consider removing days' supply and quantity limits to allow members to receive the full treatment course at one time.

ICO Coordination Activities

DAAs are safe and have few contraindications or side effects. In most cases, treatment can be prescribed by a primary care provider (PCP), though some providers may still prefer to refer these patients to a specialist for treatment. ICOs should work with their network providers to incorporate HCV testing in routine care for their patients, and should support network providers in treating patients or facilitating the referral process.

ICOs should also focus efforts on outreach to beneficiaries on the importance of being tested for HCV, and should work with community health workers (CHWs) to contact beneficiaries who may be difficult to reach, including those who are homeless, transient, disabled, or non-English speakers. Further details on care coordination requirements are below.

- **Provider Outreach**
  - Conduct outreach to network providers on the CDC's new universal testing guidelines
  - Work with providers to incorporate orders for HCV tests in routine care for patients
  - Ensure that CDC HCV testing algorithms are followed (running an HCV virus detection test or PCR for any persons who test positive for HCV antibody)
  - If a beneficiary tests positive for HCV, the ICO should work with network providers to initiate treatment
  - MDHHS has partnered with organizations to make a variety of resources available to providers treating HCV patients. These resources include:
    - Consulting line for all health care professionals with questions about HCV treatment provided by Henry Ford Health System. The consulting line operates from 8 am – 5 pm daily: (313) 575-0332
    - On-demand webinars, live training events, office hours and other resources for health care professionals on treating HCV, provided by the Midwest AIDS Training and Education Center (MATEC) at Wayne State University School of Medicine, Division of Infectious Diseases. To request an appointment, call (313) 962-2000, and for urgent questions (including after hours and weekends), call (313) 408-3483.
    - Education and case consultation on HCV through Michigan Opioid Collaborative
    - Additional resources at Michigan.gov/WeTreatHepC

[6] 129 Medicaid and HMP beneficiaries started DAA treatment in March 2021; following removal of PA on MAVYRET on April 1, 232 beneficiaries started DAA treatment in April.

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- ICOs should promote these resources to their network providers. Also, ICOs are encouraged to develop and share any additional resources that may be useful to network providers.
- Providers who want to be notified of new training opportunities and events should send a request to MDHHS-Hepatitis@michigan.gov to be added to the listserv.
- In addition to general outreach, ICOs should provide targeted outreach and support to providers in areas where HCV is prevalent.
- To promote medication adherence, ICOs should work with providers to specify on the DAA prescription that the full treatment course should be dispensed at one time.

- **Beneficiary Outreach**
  - Send letter to all your members with general information on HCV and getting tested using beneficiary letter template. Consider including the *Hepatitis C in Baby Boomers Fact Sheet* with member letters.
  - Include information about hepatitis C and the importance of getting tested in beneficiary newsletter.
  - Provide materials in beneficiaries' preferred language. Ensure communication efforts meet national Culturally and Linguistically Appropriate Services (CLAS) standards.
  - MDHHS creative assets are available for ICOs to share via social media/websites
  - Utilize CHWs, Community Based Organizations and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders.
  - Ensure that beneficiaries have access to providers, laboratories and pharmacies through transportation, telemedicine and mail order where appropriate.
  - Incorporate hepatitis C testing in all care management/care coordination discussions.
  - ICOs must develop a roster of beneficiaries with an HCV diagnosis and without a record of treatment. The roster should include housing information, to assist with this high-risk population, and primary spoken language to provide appropriate outreach materials. ICOs should contact these beneficiaries by phone.
  - Follow-up with beneficiaries who have a positive HCV test as well as their providers on initiating treatment

- **Pharmacy Outreach**
  - Ensure that network pharmacies in areas where HCV is prevalent have adequate stock of DAAs
  - To promote medication adherence, ICOs should work with providers and pharmacies to ensure that the full treatment course of the DAA is dispensed at one time. In most cases, the full treatment course is 8-12 weeks.

HCV and Health Equity

The HCV epidemic and its unchecked growth among communities of color, people who inject drugs, immigrants, justice-involved individuals and others are symptoms of larger systems of stigma and health inequity. African Americans have a chronic HCV infection rate that is 2.4 times higher than that of Caucasians.[7] They also have a higher rate of chronic liver disease, which is often hepatitis C-related. In addition, African Americans have the highest mortality rates of liver cancer, of which HCV is a major cause.[8] A significantly lower proportion of African Americans receive HCV confirmatory testing and

[8] Islami, et al. Disparities in liver cancer occurrence in the United States by race/ethnicity and state. Ca Cancer J Clin 2017;67:273–289 at 275.

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genotype testing (a marker that the patient is being evaluated for treatment) compared to Caucasians.

The significant disparity in access to health services for communities of color means that further interventions are needed to address health inequity. As ICOs develop their strategies to identify and treat beneficiaries with HCV, they should consider Social Determinants of Health to ensure the equitable access to health care and treatment among all their members, including members of racial/ethnic minorities, those whose primary language is not English, those in rural areas, and those with disabilities. Earlier diagnosis, improved HCV testing, linkage to care, and treatment can greatly improve HCV-related health outcomes and reduce racial disparities.

Reporting and Monitoring

Over the next year, MSA will collaborate with ICOs to develop performance measures on HCV screening and treatment. While reviewing their member population to determine whether members have received HCV tests or have an HCV diagnosis, ICOs may find the following codes helpful:

- CPT Codes for HCV Antibody Test
  - 86803
  - 86804
  - 80074
- CPT Codes for HCV RNA Test
  - 87520
  - 87521
  - 87522
- HCPCS Code for HCV Testing for High-Risk Individuals
  - G0472
- Diagnosis Codes for Chronic HCV
  - ICD-9
    - 070.44
    - 070.54
  - ICD-10
    - B182
- National Drug Codes (NDC) for DAAs

Brand Name	Generic Name	NDC standardized to 11 digits
DAKLINZA	daclatasvir	00003001101
DAKLINZA	daclatasvir	00003021301
DAKLINZA	daclatasvir	00003021501
ZEPATIER	elbasvir and grazoprevir	00006307402
VIEKIRA XR	dasabuvir and ombitasvir and paritaprevir and ritonavir	00074006301
VIEKIRA XR	dasabuvir and ombitasvir and paritaprevir and ritonavir	00074006328
TECHNIVIE	ombitasvir, paritaprevir and ritonavir	00074308228
VIEKIRA PAK	ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets	00074309328
OLYSIO	simeprevir	59676022507
OLYSIO	simeprevir	59676022528
SOVALDI	sofosbuvir	61958150101
HARVONI	ledipasvir and sofosbuvir	61958180101
EPCLUSA	sofosbuvir and velpatasvir	61958220101
MAVYRET	glecaprevir and pibrentasvir	00074262528

6

VOSEVI	sofosbuvir and velpatasvir and voxilaprevir	61958240101

Conclusion

HCV is a curable disease. Thanks to recent medical advancements in HCV treatment, no one should have to live with, or die from, HCV. The *We Treat Hep C* initiative is an exciting new chapter in MDHHS' long partnership with ICOs to improve health care quality in the state. We look forward to working with you to eliminate this deadly virus.

Resources

- Press Release #1 – July 28, 2020
- Press Release #2 - April 1, 2021
- CDC's new universal testing guidelines
- MDHHS Hepatitis C Virus Surveillance Data
- Hepatitis C General Information (cdc.gov)
- Michigan's State Plan on Eliminating Hepatitis C
- Provider Letter – L 21-21
- Website – Michigan.gov/WeTreatHepC
- Michigan Medicaid Preferred Drug List/Single PDL
- HCV Clinical Consulting Line through Henry Ford Health System
- Education and case consultation on HCV through Michigan Opioid Collaborative
- Frequently Asked Questions

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MDHHS Website Link: We Treat Hep C - Resources for Michigan Providers

2.18 Appendix 19 Quality Assurance Supplement (QAS) Section 438.6(c) Pre-Print

The 2024 Quality Assurance Supplement (QAS) Section 438.6(c) can be found at this link:
MI_Fee_NF_Renewal_20240101-20241231.pdf

2.19 Appendix 20 Provider Pay Section 438.6(c) Pre-Print

The 2024 Provider Pay Section 438.6(c) Pre-print can be found at this link:
MI_Fee_HCBS3_Renewal_20231001-20240930.pdf