MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Meghan Siguenza Vanderstelt

Director, Bureau of Policy and Strategic Engagement
Health Services Administration

Project Number:	2520-MICH	**Comments Due:**	August 18, 2025	**Proposed Effective Date:**	January 1, 2026

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Policy Subject: New Medicaid Provider Manual Chapter for the MI Coordinated Health (MICH) Program

Affected Programs: Medicaid, MI Health Link

Distribution: All Providers

Policy Summary: The purpose of this bulletin is to notify providers of the addition of a MI Coordinated Health (MICH) program chapter in the Medicaid Provider Manual. The chapter gives providers information on the new MICH program.

Purpose: Effective January 1, 2026, the MI Health Link (MHL) program will transition to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) program, called MI Coordinated Health (MICH). A HIDE SNP is a specific type of Medicare Advantage plan that is designed to meet the needs of those dually eligible for Medicare and Medicaid. HIDE SNPs will provide aligned coverage of most Medicaid benefits, excluding certain behavioral health services, but including long-term services and supports, under a capitated contract that meets the requirements set forth in 42 CFR 422.107. The HIDE SNP program will be fully operational commencing January 1, 2026, in limited regions of the State of Michigan (State). On January 1, 2027, the program will be extended to the entire State.

Proposed Policy Draft

Michigan Department of Health and Human Services
Health Services

Distribution: All Providers

Issued: December 1, 2025 (proposed)

Subject: New Medicaid Provider Manual Chapter for the MI Coordinated Health (MICH) Program

Effective: January 1, 2026 (proposed)

Programs Affected: Medicaid, MI Health Link

NOTE: Portions of this bulletin are contingent upon Centers for Medicare & Medicaid Services (CMS) approval of a 1915b/c waiver amendment.

The purpose of this policy is to notify providers of the addition of a MI Coordinated Health (MICH) program chapter in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. The chapter gives providers information on the new MICH program.

Effective January 1, 2026, the MI Health Link (MHL) program will transition to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) program called MI Coordinated Health (MICH). A HIDE SNP is a specific type of Medicare Advantage plan that is designed to meet the needs of those dually eligible for Medicare and Medicaid. HIDE SNPs will provide aligned coverage of most Medicaid benefits, excluding certain behavioral health services but including long-term services and supports, under a capitated contract that meets the requirements set forth in 42 CFR 422.107. The MICH program operates under concurrent 1915b/c waiver authorities. The HIDE SNP program will be fully operational commencing January 1, 2026, in limited regions of the State of Michigan (State). On January 1, 2027, the program is expected to extend to the entire State.

MI COORDINATED HEALTH (MICH)

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SECTION 1 – GENERAL INFORMATION

Effective January 1, 2026, the MI Health Link (MHL) program transitioned to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) program, called MI Coordinated Health (MICH). A HIDE SNP is a specific type of Medicare Advantage plan that is designed to meet the needs of those dually eligible for Medicare and Medicaid. HIDE SNPs provide aligned coverage of most Medicaid benefits, excluding certain behavioral health services but including long-term services and supports, under a capitated contract that meets the requirements set forth in 42 CFR 422.107. The MICH program operates under concurrent 1915b/c waiver authorities. The HIDE SNP program is operational, in limited regions of the state of Michigan (State).

The Michigan Department of Health and Human Services (MDHHS) contracts with HIDE SNPs, selected through a competitive bid process, to provide services to those dually eligible for Medicare and Medicaid. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The HIDE SNP State Medicaid Agency Contract (SMAC), referred to in this chapter as the SMAC, specifies the Enrollees to be served, scope of the benefits, and contract provisions with which the HIDE SNP must comply. Nothing in this chapter should be construed as requiring HIDE SNPs to cover services that are not included in the SMAC. A copy of the SMAC is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

HIDE SNPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this Manual for additional information.) The HIDE SNP must also maintain a contract with the Centers for Medicare & Medicaid Services (CMS) to operate as a HIDE SNP. Although HIDE SNPs must provide the full range of covered services listed below, HIDE SNPs may also choose to provide services over and above those specified. HIDE SNPs are allowed to develop prior authorization requirements and utilization management review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the SMAC.

1.1 HIGHLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLANS (HIDE SNPS) ELIGIBILITY AND SERVICE AREA

The HIDE SNP must operate in one or more of 12 regions throughout the State for the provision of covered services. The HIDE SNP must provide services in accordance with the SMAC to Enrollees residing in all counties within the region(s) it is approved to cover. Regions are defined and numbered as follows:

- Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft
- Region 2: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
- Region 3: Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon
- Region 4: Allegan, Ionia, Kent, Lake, Mason, Mecosta, Muskegon, Montcalm, Newaygo, Oceana, Osceola, Ottawa

- Region 5: Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw
- Region 6: Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola
- Region 7: Clinton, Eaton, Ingham
- Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
- Region 9: Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
- Region 10: Macomb
- Region 11: Oakland
- Region 12: Wayne

The following individuals will be excluded from initial and ongoing enrollment with the HIDE SNP unless otherwise indicated:

- Individuals under the age of 21
- Individuals previously disenrolled from the HIDE SNP due to special disenrollment from Medicaid managed care as defined in 42 C.F.R. § 438.56
- Individuals not living in a HIDE SNP service area
- Individuals who are eligible for partial Medicaid coverage through the following eligibility groups: Additional Low Income Medicare Beneficiary (ALMB), Qualified Individual (QI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Disabled and Working Individuals (QDWI)
- Individuals without full Medicaid coverage (including those with spenddowns or deductibles)
- Individuals with Medicaid who reside in a State psychiatric hospital
- Individuals with other comprehensive health coverage, including commercial health maintenance organization (HMO) coverage
- Individuals who elected hospice services prior to HIDE SNP enrollment
    - If an existing HIDE SNP Enrollee elects for hospice services, the Enrollee may remain Enrolled in the HIDE SNP and will only be disenrolled at the Enrollee's request.
- Individuals who are incarcerated
- Individuals with presumptive eligibility
- Individuals not eligible for Medicaid due to divestment
- Individuals residing in designated State sanctioned Veterans' Homes
- Individuals who elect hospice

For Enrollees who are transitioning from MI Choice or PACE:

- The HIDE SNP must obtain a signed Acknowledgment form at the time of enrollment from all Enrollees receiving services from MI Choice or PACE immediately prior to enrollment with the

HIDE SNP. The Acknowledgment Form will be standardized and provided by MDHHS. Refer to the Directory Appendix for information regarding the Acknowledgement Form Resource Guide

1.2 SERVICES COVERED BY HIDE SNPS

MICH offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services, hearing aid coverage, and Medicaid drugs.
- Dental services
  - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this Manual
- Long Term Supports and Services (LTSS)
  - Nursing facility services
  - State Plan Personal Care Services (PCS)
  - MICH Home and Community-Based Services (HCBS) Waiver services for Enrollees who live in the community and meet nursing facility level of care as determined by the level of care determination (LOCD)
- Services provided through Prepaid Inpatient Health Plans (PIHPs) for an Enrollee's needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

The MICH program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed DCH-3877 Pre-Admission Screening and Resident Review (PASRR).

HIDE SNPs must provide an integrated Medicare-Medicaid benefit package to the greatest extent possible. When Michigan Medicaid covers services not covered by Medicare or covers a needed service in a greater amount, duration, or scope than Medicare, HIDE SNPs must provide these services through Medicaid. In instances when the Medicaid limit for a service exceeds the Medicare limit for the same service, HIDE SNPs must cover the service up to the Medicaid limit.

HIDE SNPs must cover all Michigan Medicaid State Plan and services detailed in HIDE SNP 1915(b)/(c) Waiver applications, except as set forth in the SMAC, and outlined below.

HIDE SNPs must provide the following Medicaid services and any outreach necessary to facilitate Enrollees' use of appropriate services. HIDE SNPs may choose to provide services over and above those specified:

- Ambulance and other emergency medical transportation
- Breast pumps; personal use, double-electric
- Behavioral health services consistent with Appendix E of the SMAC

- Certified nurse midwife services
- Certified family nurse practitioner services
- Chiropractic services
- Community Health Workers
- Dental services for adults aged 21 and older
- Diagnostic laboratory, x-ray, and other imaging services
- Doula services
- Durable medical equipment (DME) and supplies, including those that may be supplied by a pharmacy
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home and Community-Based Services
- Home Health services
- Hospice services (if elected by the enrollee after initial enrollment))
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services in a nursing facility
- Long-term care acute hospital (LTACH) services
- Maternal and Infant Health Program (MIHP) services
- Medically necessary weight reduction services
- Michigan Diabetes Prevention Program (MiDPP)
- Non-emergency medical transportation (NEMT) to medically necessary covered services and Medicaid services covered outside of the SMAC
- Nursing facility
- Custodial Care Nursing Facility Care
- Skilled Nursing & Rehabilitation services (The Medicare requirement for a three-day hospital stay prior to admission to a nursing facility is not required.)
- Nursing facility mental health monitoring
- Out-of-state services authorized by HIDE SNP

- Parenting and birthing classes
- Personal Care services
- Pharmacy services
- Podiatry services
- Practitioner services
- Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS
- Prosthetics and orthotics
- Restorative or rehabilitative nursing services
- Service animal stipend
- Sexually transmitted infections (STI) treatment
- Tobacco cessation treatment, including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational, family, individual, group, and therapies to support activities of daily living); excluding therapies billed through PIHPs, including therapy provided to persons with intellectual and/or development disabilities (I/DD) or provided by Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts
- Transplant services
- Vision services

HIDE SNPs must provide supplemental services in accordance with the requirements of the SMAC.

1.2.A. State Plan Personal Care Services

For MICH Enrollees, State Plan personal care services (PCS) are provided and paid for by the HIDE SNP and are not provided through the Medicaid Home Help program. Personal care services are available to Enrollees who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

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

An assessment assists in identification of service needs. Enrollees with more basic needs may be served by adults who are capable of communicating with the Enrollee and being responsive to their needs. Enrollees with more complex needs or more specialized problems must be served by individuals who can demonstrate their competence through experience or training. For additional information, refer to the Complex Care Needs section below, and to the Directory Appendix for information regarding the MICH Personal Care Services Resource Document.

Providers shall be qualified individuals who work independently, contract with, or are employed by a Medicaid Enrolled agency. The HIDE SNP may directly hold provider agreements or contracts with independent care providers of the Enrollee's choice if the provider meets MDHHS qualification requirements to provide personal care services. Enrollees who receive personal care services from an independent care provider, prior to enrollment with the HIDE SNP, may elect to continue to use that provider. The Enrollee may also select a new provider if that provider meets State qualifications. Paid family caregivers are permitted to serve as a personal care provider in accordance with State requirements for Medicaid State Plan personal care services.

HIDE SNPs 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 section and the MICH Personal Care Services Resource Document.

Personal care services are subject to Electronic Visit Verification (EVV) in accordance with the EVV chapter of this Manual.

1.2.A.1. PROVIDER QUALIFICATIONS

A criminal history screen must be conducted for all personal care providers. In addition, the provider must meet the following qualifications:

- Be 18 years of age or older
- Be able to follow instructions and personal care procedures, perform the services required and handle emergencies
- Be physically able to perform the needed services
- Be knowledgeable about when to seek assistance from appropriate sources in the event of an emergency
- Be dependable and able to meet job demand
- 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.

The HIDE SNP 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.

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 Medicaid policy.

1.2.A.2. Assessment Requirements

During the Health Risk Assessment (HRA) (refer to the Enrollee Stratification, Assessments, and Integrated Care Plan (ICP) section of this chapter), HIDE SNP Care Coordinators (or designee who meets the qualifications for a HIDE SNP Care Coordinator) must consider if the Enrollee may need personal care services. If the HIDE SNP Care Coordinator believes the Enrollee may be eligible for MICH personal care services, the HIDE SNP Care Coordinator will conduct the Personal Care Assessment. MDHHS will provide the HIDE SNP with the Personal Care Assessment tool specifications to determine time and task for the Enrollee. 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.

1.2.A.3. Reassessment

The HIDE SNP 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 HIDE SNP 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 reassessment must be documented care coordination platform.
- If there is a change of functional and/or health status, a new in-person Personal Care Assessment must be completed, which would start a new six-month reassessment schedule. Note: If the Enrollee, provider, authorized/legal representative or guardian believes the Enrollee's functional and/or health status changed before the time of reassessment, the HIDE SNP must complete a new Personal Care Assessment, which would also start a new six-month schedule.

1.2.A.4. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

ADLs and IADLs are ranked by the HIDE SNP 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.

Independent	The Enrollee performs the activity with no human assistance.
Verbal assistance	The Enrollee performs the activity with verbal assistance such as reminding, guiding or encouraging.
Minimal assistance	The Enrollee performs the activity with some direct physical assistance and/or assistance technology.
Moderate assistance	The Enrollee performs the activity with a great deal of human assistance and/or assistive technology.
Dependent	The Enrollee does not perform the activity even with human assistance and/or assistance technology.

An Enrollee must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment 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, their authorized ADL and IADL services and the amount, scope and duration must be included in the Integrated Care Plan (ICP).

The MICH Personal Care Services Resource document provides guidance on completing the Personal Care Assessment, Personal Care Assessment Tool specifications, and additional guidance related to personal care. Refer to the Directory Appendix for information on document location.

1.2.A.4.1. Maximum Allowable Hours for IADLs

There are monthly maximum hour limits on all IADLs except taking medication. The limits are as follows:

IADL	Maximum Hours per Month
Shopping	5
Light housework	6
Laundry	7
Meal preparation	25

1.2.A.5. Personal Care Services and the MICH HCBS Waiver

If an Enrollee ranks at a level 1 or 2, they are not eligible for State Plan Personal Care Services through MICH. If an Enrollee ranks at a level 2, they may be eligible for ADL assistance through the MICH 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 they qualify for ECLS due to a need for prompting, cueing, guiding, etc. to complete ADLs. The HIDE SNP Care Coordinator must ensure the Nursing Facility Level of Care Determination Tool

(refer to the MDHHS Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) website) is performed to determine if the Enrollee qualifies to receive MICH 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. PCS and ECLS may also be provided for the same ADLs or IADLs but at different times during the day. Additional information on ADLs and IADLs can be found in the MICH HCBS Waiver Resource Document. Refer to the Directory Appendix for document location information

1.2.A.6. Reasonable Time and Task

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an Enrollee, so these are case maximums. When an Enrollee's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the Enrollee's health record.

Additional guidance on Reasonable Time and Task is available in the MICH Personal Care Services Resource document. Refer to the Directory Appendix for document location information.

1.2.A.6.1. 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 an Enrollee's home or the caregiver's home to perform this task.

Individual PCS 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 HIDE SNP 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 HIDE SNP will be based on information obtained from the Enrollee and the provider. Provider time needed to complete a Enrollee'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 Enrollee residence is located. The HIDE SNP must consider the Enrollee's wishes, dietary needs, religious and cultural preferences and beliefs, as well as other possible exceptions, when authorizing travel time for shopping.

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 HIDE SNP within ten calendar days. For example, this can occur if the Enrollee has a change in residence or a different store or laundromat must be visited because of closure or change in Enrollee preference. The payment to cover travel time for shopping and laundry will be added in the regular payment to the PCS provider.

1.2.A.7. 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 additional management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or individual may be required in order to perform.

- 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 HIDE SNP 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. When hours exceed the RTS, a rationale must be provided and maintained in the Enrollee's record.

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

1.2.A.8. Reimbursement and Rates

After enrollment, and according to the requirements of the SMAC, the HIDE SNP must maintain the Enrollee's current personal care providers and amount, scope and duration of services until the ICP is reviewed and updated and providers are secured with the Enrollee's approval. If an Enrollee is transitioning from Home Help, the HIDE SNP should use the Medicaid Home Help Payment Schedule to continue paying providers as scheduled. (Refer to the Directory Appendix for additional information.) A HIDE SNP should follow this schedule until the HIDE SNP and personal care provider agree upon a new payment schedule, which should be defined in the contract between the HIDE SNP and the personal care provider. The HIDE SNP must publish a pay cycle and must pay these claims on the next available pay cycle date.

The HIDE SNP may set their own rates for Direct Care Worker Wages and are not required to match Home Help rates noted in the Individual and Agency County Rates, located in the Adult Services Manual (ASM). Refer to ASM for more information. A link to the ASM Table of Contents is available in the Directory Appendix.

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

A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADLs, except for administering medications) and responsible relatives able and available to assist.

If the Enrollee does not require the maximum allowable hours for IADLs, only the amount of time needed for each task shall be authorized. Assessed hours for IADLs (except medication administration) 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. 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 Enrollee are completed separately from others in the home, hours for IADLs do not need to be prorated.

1.2.A.9. Responsible Relatives and Guardians

Adult children (18 years of age or older) may provide personal care services to a parent. An Enrollee's spouse cannot be paid to provide personal care services to the Enrollee as they are considered responsible relatives. Couples who are separated must provide verification that they are no longer residing in the same home. Verification may include a 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. "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.

Shopping, laundry, or light housecleaning shall not be approved when a responsible relative of the Enrollee resides in the home unless they are unavailable or unable to provide these services. These findings must be documented.

Additional guidance on Responsible Relatives is available in the MICH Personal Care Services Resource document. Refer to the Directory Appendix for document location information.

1.2.A.10. Personal Care Supplement for Enrollees in Adult Foster Care (AFC) Facilities, Homes for the Aged (HFA) and Unlicensed Congregate Residential Settings

For Enrollees in adult foster care facilities or homes for the aged, a flat monthly supplement rate is established annually by the state legislature for those Medicaid Enrollees who, according to a standardized assessment, have a documented need for personal care services. The supplement rate is included in the HIDE SNP rates, and HIDE SNPs must pay this rate to adult foster care homes and homes for the aged providers for MICH Enrollees. HIDE SNPs and Adult Foster Care facilities and Homes for the Aged must use the billing invoice provided by MDHHS. The Personal Care Supplement billing invoice will be provided in the MICH Personal Care Services Resource Document. Refer to the Directory Appendix for document location information.

AFCs or HFAs receive payment from the HIDE SNP if the Enrollee meets all three of the following criteria:

- Receives Medicaid
- Lives in a Michigan licensed AFC facility or HFA
- Scores at a 2 or above on the Personal Care Assessment for ADL and/or a 5 for medication administration

Note: If the Enrollee 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 ASM. Refer to ASM for more information. A link to the ASM Table of Contents is available in the Directory Appendix.

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 HIDE SNP 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.

HIDE SNPs are 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 HIDE SNPs for the payment.

Personal care supplements are not paid by HIDE SNPs in instances where the residential setting is certified as a specialized residential setting through MDHHS/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.

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, HIDE SNPs cannot pay hourly for personal care in settings that should be licensed except in the case of a Supported Independent Setting (SIP).

- 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 cannot be the individual caregiver or agency provider of the Home Help client.

1.2.A.11. Resident Care Agreements in AFC Licensed Settings

Licensed 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 their authorized/legal representative or guardian and the HIDE SNP as soon as possible since the HIDE SNP is responsible for paying the personal care supplemental payment.

Per R400.14301, it is a requirement for this agreement to be reviewed with the Enrollee or the Enrollee's authorized/legal representative or guardian and responsible agency at least annually. If information within the agreement did not change, the HIDE SNP will not need to complete a new agreement; however, MDHHS expects the licensee (AFC provider) to have a process to document that the agreement was reviewed. 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/ initial and date the current 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.

1.2.A.12. SERVICE ANIMAL STIPEND

HIDE SNP must provide a $20 monthly stipend for care and maintenance of a Service Animal, paid directly to the Enrollee, when coverage criteria is met.

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.

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

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

- The Enrollee is receiving personal care services.
- The Enrollee is certified as disabled due to a specific condition such as arthritis, visual impairment, cerebral palsy, polio, multiple sclerosis, hearing impairment, stroke or spinal cord injury, among others.
- The service animal is trained to meet the specific needs of the Enrollee relative to their 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 Enrollee.

Additional guidance on Service Animals is available in the MICH Personal Care Services Resource document. Refer to the Directory Appendix for document location information.

1.2.A.13. MANDATORY AND PERMISSIVE EXCLUSIONS

All MICH Enrolled providers, and non-enrolled atypical providers who will be entering the homes of Enrollees (including personal care providers and applicants), directly contracted or subcontracted with the HIDE SNP, or any person with a five percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks as a condition of participation in accordance with Medicaid policy. Refer to the General Information for Providers Chapter of this Manual for additional information. The requirements and criteria outlined in the General Information for Providers Chapter apply to non-enrolled atypical MICH providers who will be entering the homes of Enrollees in addition to Enrolled providers.

The HIDE SNP should reference the MICH Acknowledgment of Exclusions Resource Document for additional information on the requirements for notification of mandatory and permissive exclusions and the process for the termination and summary suspension of current providers. (Refer to the Directory Appendix for document location information.)

1.2.A.14. Continuity of Care for Personal Care Services

For those enrolled with the HIDE SNP, then disenrolling, then returning to the HIDE SNP, the HIDE SNP must allow a continuity of care period for personal care services. The HIDE SNP must continue services based on the personal care services received at the time of the disenrollment. If the Enrollee did not receive personal care services external to the HIDE SNP during the period of HIDE SNP disenrollment, the Enrollee can be disenrolled with the HIDE SNP for three 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 HIDE SNP during the period of HIDE SNP disenrollment, the HIDE SNP 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 Enrollees receiving services through the PIHP under the Managed Specialty Services and Supports Program (MSSSP) or Habilitation Supports Waiver
- 90 days for all other Enrollees

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

1.2.B. Home and Community Based Services (HCBS) Waiver Services

The HIDE SNP must provide home and community-based waiver services in accordance with Medicaid State Plan and HIDE SNP 1915c waiver application requirements.

The HIDE SNP must use an assessment tool identified by the State to determine the amount, scope and duration of the services required for the Enrollee to live in the community and use person-centered planning to determine how the services will be delivered as detailed in the ICP.

These services are intended for Enrollees who meet the following criteria:

- Meet nursing facility level of care as determined by the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool; and
- Demonstrate a need for one or more of the services listed below, which must be identified in the ICP.

Individuals must receive at least one waiver service each month to remain on the waiver. The HIDE SNP and direct service providers must adhere to the service definition and operating standards to be eligible to receive payment of waiver expenses. Waiver service

codes can be found in the MICH HCBS Waiver Resource Document. (Refer to the Directory Appendix for document location information).

1.2.B.1. Adaptive Medical Equipment and Supplies

Adaptive Medical Equipment and Supplies includes services, controls, or appliances specified in the ICP that enable Enrollees to increase their abilities to perform ADL, 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 HIDE SNP 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.

Adaptive Medical Equipment and Supplies also covers 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.

It must be documented on the ICP or case record that the item is the most cost-effective alternative to meeting the Enrollee's needs.

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

Items must be of direct medical or remedial benefit to the Enrollee, and this benefit must be documented in the ICP.

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).

The HIDE SNP may obtain some items directly from a retail store that offers the item to the general public. When utilizing retail stores, the HIDE SNP must ensure the item purchased meets the service standards. The HIDE SNP may choose to open a business account with a retail store for such purchases. The HIDE SNP must maintain the original receipts and maintain accurate systems of accounting to verify the specific Enrollee who received the purchased item.

Where feasible, the HIDE SNP and/or direct service provider shall seek confirmation of the need for the item from the Enrollee's physician.

The HIDE SNP shall not authorize waiver payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not authorized by the Food and Drug Administration (FDA).

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, specialized turner or pointer, mouthstick for Technology for the Deaf and Disabled (TDD), foot massaging unit, talking timepiece, adaptive eating or drinking device, book holder, medical alert bracelet, adapted mirror, weighted blanket, and back knobber.

If a HIDE SNP 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 ICP cannot be restrictive in nature and does not eliminate the need for adequate supervision, nor does it replace individualized, person-centered care planning.

Direct service providers must enroll in Medicare and Medicaid as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider, pharmacy, etc., as appropriate. Medicare and Medicaid enrollment must be verified at the beginning of service delivery and annually thereafter.

Additional information on HCBS Waiver Adaptive Medical Equipment provider qualifications is available in the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.2. ADULT DAY PROGRAM

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 ICP, 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 HIDE SNP will pay for the transportation to and from the Adult Day Program center separately.

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

Adult Day Program may be authorized only if the Enrollee meets at least one of the following criteria:

- Requires regular supervision to live in their own home or the home of a relative.
- If they have a caregiver, the Enrollee must require a substitute caregiver while their regular caregiver is unavailable.
- Has difficulty or is unable to perform ADLs without assistance.
- Capable of leaving the residence with assistance to receive services.
- In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization.

A referral from a HIDE SNP for a waiver Enrollee shall replace any screening or assessment activities performed for other Adult Day Program individuals at the setting. The direct Adult Day Program service provider shall accept copies of the HIDE SNP's assessments and ICP to eliminate duplicate assessment and service planning activities.

Each program shall provide directly, or coordinate with the HIDE SNP to arrange for the provision of, the following services:

- Transportation
- Personal Care
- 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 8-14 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 individual choice, health, religious and ethnic diet preferences.
- 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. The HIDE SNP shall provide care coordination.

Each program shall keep all Enrollees' 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.

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 (RN). 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 the other individual or organization.

Each program shall establish written procedures (reviewed and approved by a consulting pharmacist, physician, or RN) 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:

- Written consent from the Enrollee or Enrollee's authorized/legal representative or guardian to assist with medications.
- Verifications of the Enrollee's medication regimen, including prescriptions and dosages.
- 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.
- Procedures for medication set up.
- Secure storage of Enrollee's medications. Medications must be returned to the Enrollee.
- Instructions for entering medication information in Enrollee files, including times and frequency of assistance.

Program staff shall have basic first-aid training and any other training as required by MDHHS and the HIDE SNP.

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:

- The Secretary of State shall appropriately license all drivers and vehicles, and all vehicles shall be appropriately insured.
- 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.
- All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
- Each program shall operate in compliance with Public Act (PA) 1 of 1985 regarding seat belt usage.

The provider shall maintain all equipment and furnishings used during program activities or by program Enrollees in safe and functional condition. Each Adult Day Program center must have the following furnishings:

- At least one straight back or sturdy folding chair for each Enrollee and staff person.

- Lounge chairs and/or day beds as needed for naps and rest periods.
- Storage space for Enrollees' personal belongings.
- Tables for both ambulatory and non-ambulatory Enrollees.
- A telephone accessible to all Enrollees.
- Special equipment as needed to assist persons with disabilities.

Each provider shall post emergency procedures (fire, severe weather, etc.) in each room of the program site. Practice drills of emergency procedures must occur once every six months. The program shall maintain a record of all practice drills.

Each Adult Day Program center must document that it is in compliance with:

- Barrier-free design specification of Michigan and local building codes.
- Fire safety standards.
- Applicable Michigan and local public health codes.

Adult Day Program settings must be compliant with the HCBS Final Rule as indicated in the Home and Community-Based Residential and Non-Residential Settings subsection of this chapter.

For additional information on HCBS Waiver Adult Day provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.3. ASSISTIVE TECHNOLOGY

The Assistive Technology service includes 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.

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 Enrollee's needs, a description of their abilities without assistive technology, 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 ICP.
- Training or technical assistance for the Enrollee, or, where appropriate, family members, guardians, advocates, or authorized/legal representative or guardian of the Enrollee.
- 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.

Cost limits for this service are as follows:

- $5,000 yearly (waiver year) maximum for all assistive technology devices

Items must be of direct medical or physical benefit to the Enrollee. Where feasible, the HIDE SNP and/or direct service provider must seek confirmation of the need for the item from the Enrollee's physician. It must be documented in the ICP that the item is the most cost-effective alternative to meeting the Enrollee's needs. Items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.

The HIDE SNP may obtain some items directly from a retail store that offers the item to the general public. When utilizing retail stores, the HIDE SNP must ensure the item purchased meets the service standards. The HIDE SNP may choose to open a business account with a retail store for such purchases. The HIDE SNP must maintain the original receipts and maintain accurate systems of accounting to verify the specific Enrollee who received the purchased item.

Where feasible, the HIDE SNP and/or direct service provider shall seek confirmation of the need for the item from the Enrollee's physician.

The Enrollee's privacy must be protected while utilizing assistive technology. Video recording is not allowed. The HIDE SNP should support Enrollees 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. The HIDE SNP Care Coordinator should identify and discuss potential risks with the Enrollee during the assessment and reassessments, i.e., assistive technology related to privacy for Enrollees.

Items like cell phones, internet service, and full-home wiring systems are excluded from this benefit. This service also does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.

Direct service providers must enroll in Medicare and Medicaid as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider, pharmacy, etc., as appropriate. Enrollment must be verified at the beginning of service delivery and annually thereafter. Contracted/subcontracted providers must have 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. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the HIDE SNP and/or the SMAC. For additional information on HCBS Waiver Assistive Technology provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.4. CHORE SERVICES

Chore Services include those duties 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, cleaning hazardous debris such as fallen branches and trees, weatherization, and pest control. The service may include materials and disposable supplies used to complete chore tasks. The HIDE SNP may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver Enrollees.

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

The HIDE SNP may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver Enrollees.

Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the ICP. The HIDE SNP must deem the chosen provider capable of performing the required tasks. 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. The HIDE SNP must develop working relationships with service providers, as available, in their program area to ensure effective coordination of efforts. Pest control suppliers must be properly licensed. For additional information on HCBS Waiver Chore Services provider

qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.5. ENVIRONMENTAL MODIFICATIONS

Environmental Modifications are physical adaptations to the primary residence, or the Enrollee's family residence if applicable, required by the Enrollee's ICP 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 (suction cup grab bars are prohibited), widening of doorways, modification of bathroom facilities, or installation of specialized electrical 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, the HIDE SNP can use a standard remark to provide waiver coverage for the installation.

Porch/patio/stair railings may be provided as long as it is directly related to enhancement of the Enrollee's mobility.

Patios, decks, stairs or walkways may be installed or restructured if directly related to enhancement of the Enrollee's mobility.

Environmental modifications such as ramps, etc., are NOT limited to Enrollees in wheelchairs. Ramps may be provided for anyone who has mobility challenges with 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.

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.

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 MICH 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 Enrollee's health and welfare, the Care Coordinator should document this assessment and may proceed with implementing the environmental modification.

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).

The modification/adaptation must be for a primary residence but may include additional residences subject to prior authorization by the HIDE SNP. 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.

The HIDE SNP may use MICH 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.

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

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

Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the Enrollee, and the HIDE SNP must specify any requirements for restoration of the property to its original condition if the occupant moves. If the HIDE SNP is experiencing a scenario in which the landlord is refusing to allow reasonable modifications for Enrollees with disabilities to be completed on their properties, the landlord may have an obligation to allow the reasonable accommodation. Refer to the federal Fair Housing Act for details.

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.

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

Excluded are those adaptations or improvements to the home that:

- Are of general utility.
- Are considered to be standard housing obligations of the Enrollee or homeowner (see examples in specific exclusions listed below of modifications that would be general utility and a standard obligation of the Enrollee).
- Are not of direct medical or remedial benefit to the Enrollee.
    - For example, a kitchen modification required for the Enrollee to prepare their 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.

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.

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

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

Environmental 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.

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

The HIDE SNP 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 ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the Enrollee has mobility limitations. However, MICH 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 HIDE SNP may fund the difference

between the standard fixture and the modification required to accommodate the Enrollee's need.

A ramp or lift will be covered for only one exterior door or other entrance unless otherwise approved by MDHHS.

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).

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.

The HIDE SNP must ensure 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 HIDE SNP 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.

For additional information on HCBS Waiver Environmental Modifications provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. Refer to the Directory Appendix for document location information.

1.2.B.6. EXPANDED COMMUNITY LIVING SUPPORTS

To receive Expanded Community Living Supports (ECLS), Enrollees MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete 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 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 IADLs independently if they choose. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.

ECLS includes:

- 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.).
- If, and only if, the Enrollee qualifies for ECLS based on ADL needs, they 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:
  - Money management

- Non-medical care (not requiring nursing or physician intervention)
- Social participation, relationship maintenance, and building community connections to reduce personal isolation
- 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
- Participation in regular community activities incidental to meeting the Enrollee's community living preferences
- Attendance at medical appointments
- Acquiring or procuring goods and services necessary for home and community living
- Reminding, cueing, observing, and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the Enrollee in order that they may reside and be supported in the most integrated independent community setting.
- Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
- Dementia support including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the Enrollee as identified in the Enrollee's ICP.
- Observing and reporting to the Care Coordinator any changes in the Enrollee's condition and the home environment.

If the Enrollee has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, ECLS services that only require verbal cueing may be provided via Health Insurance Portability and Accountability Act (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 ICP. If virtual method is utilized, the Enrollee's privacy must be protected during virtual visits. Video recording is not allowed. The HIDE SNP should support Enrollees 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.

When ECLS services provided to the Enrollee include transportation, the following standards apply:

- The HIDE SNP may not use MICH funds to purchase or lease vehicles for providing transportation services to waiver Enrollees.
- The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MICH funds. The provider must cover all vehicles used with liability insurance.

- All paid drivers for transportation providers supported entirely or in part by MICH 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.
- The provider shall train all paid drivers for transportation programs supported entirely or in part by MICH funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
    - Each provider shall operate in compliance with PA 1 of 1985 regarding seatbelt usage.
    - 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 MICH 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.

ECLS cannot be provided in circumstances where they would be a duplication of services available through MICH. The distinction must be apparent by unique hours and units in the approved ICP.

ECLS does not include the cost associated with room and board.

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 Enrollees to get out into the community when it is incidental to the ICP. When transportation incidental to the provision of ECLS is included, the HIDE SNP shall not also authorize transportation as a separate waiver service for the Enrollee.

ECLS services cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere.

ECLS excludes nursing and skilled therapy services.

Members of an Enrollee's family may provide ECLS to the Enrollee. Family members who provide this service must meet the same standards as providers who are unrelated to the Enrollee. Spouses and legally responsible adults are allowed to be paid providers of ECLS when the Enrollee requires extraordinary care and it is in the best interest of the enrollee. The legally responsible individual must be hired by a home care agency that will provide supervision and oversight to ensure services are being delivered and that payment is made for the services rendered. Spouses and legally responsible adults must not be hired via self-determination. (Refer to the MICH 1915c waiver application

Appendix C Section 2 Subsection d for details related to what constitutes extraordinary care and best interest of 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.

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 ensure the provider can competently and confidently perform each assigned task.

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 at the same time 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.

It is permissible 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 Enrollee 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 the appropriate service code.

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 ICP and other documentation and billed under the appropriate procedure codes to avoid duplication of services.

With the assistance of the Enrollee and/or Enrollee's caregiver, the HIDE SNP 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.

When authorizing ECLS for Enrollees choosing the self-determination option, the HIDE SNP must comply with service definitions described in the Minimum Standards for Traditional Service Delivery specified in the MICH HCBS Waiver Resource Document. (Refer to the Directory Appendix for document location information.)

Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.

Providers must meet the same qualifications as those under the traditional service delivery model.

When ECLS services provided to the Enrollee include tasks specified above, 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.

There are additional standards for Enrollees who reside in licensed settings:

- 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.
- Documentation in the Enrollee's record must clearly identify the Enrollee's need for additional supports and services not covered by licensure.
- The ICP must clearly identify the portion of the Enrollee's supports and services covered by ECLS.

For additional information on HCBS Waiver ECLS provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

ECLS services are subject to Electronic Visit Verification (EVV) in accordance with the EVV chapter of this Manual.

1.2.B.7. FISCAL INTERMEDIARY

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 ICP, managing and directing 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 ICP.

FI services are available only to Enrollees participating in arrangements that support self-determination. Additionally, FI services may not be provided by the Enrollee's family, guardian, or providers of other services for the same Enrollee.

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 identifying potential over and under expenditures; ensuring 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.

Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.

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.

Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.

Each FI will provide four basic areas of performance:

- Function as the employer agency for Enrollees directly employing workers to ensure compliance with payroll tax and insurance requirements.
- 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.
- 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 HIDE SNP.
- Offer supportive services to enable Enrollees to self-determine and direct the supports and services they need.

The HIDE SNP and FI must abide by the MICH Self-Determination Implementation Technical Advisory Resource Document and any other requirements set forth by MDHHS. (Refer to the Directory Appendix for document location information.)

For additional information on HCBS Waiver Fiscal Intermediary provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.8. Home Delivered Meals

This service is the provision of one to two nutritious 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. HIDE SNPs must follow the minimum operating standards for this service as well as ensure provider qualifications, as provided by MDHHS, are met prior to delivery of services and annually thereafter.

Each HIDE SNP 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 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 agree to be home when meals are delivered. For any unavoidable absence, the provider or HIDE SNP must be contacted. If the HIDE SNP is contacted, they must contact the provider. In the case of an occasional temporary absence such as a doctor's appointment, the provider may leave the meals with a designated caregiver, or household member if approval for such is reflected on the ICP.
- The enrollee must be able to prepare the meals at home or have a caregiver that can prepare the meals on the enrollee's behalf.
- If the Enrollee has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, home delivered meals 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 Enrollee's ICP.

Home Delivered Meal services include meal delivery kits and grocery delivery services. Meal delivery kit providers offer a service that sends pre-portioned ingredients, recipes, and directions to customers, usually as a subscription service. This allows the Enrollee to cook fresh, homemade meals at home. Meal kit providers must offer a variety of meals from which the Enrollee may choose and that meet the nutritional need of the Enrollee. When meal delivery kits are utilized, they constitute no more than the equivalent of two meals/day. The ICP must reflect the need and whether the home delivery kit meets the needs of the Enrollee (e.g., Enrollee has a need for access to groceries or a preference for meal delivery kits and Enrollee 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.

To be eligible for meal delivery kits, the following must be met:

- The meals are for the Enrollee.
- The Enrollee must be able to prepare the meal or have someone available to prepare the meal.
- The Enrollee must have the capacity to properly store the meal components.

Home Delivered Meals also includes service or membership fees for grocery delivery services. Grocery delivery services must not include payment for the food. In order to qualify for grocery delivery services, Enrollees must have difficulty with one or more of the following, or be in quarantine due to illness or public health emergency:

- Traveling to the grocery store
- Selecting groceries in the store
- Transporting groceries from store to home

Additional guidance on Home Delivered Meals is included in the MICH HCBS Waiver Home Delivered Meals Service Guidelines. Additional information on HCBS Waiver Home Delivered Meals provider qualifications is included in the MICH HCBS Waiver

Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.9. INDIVIDUAL DIRECTED GOODS AND SERVICES

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through either the MICH waiver or the Medicaid State Plan that address an identified need in the individual plan of services (IPOS) (including improving and maintaining the Enrollee'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
- Increase the Enrollee's safety in the home environment

These goods and services are only available if the Enrollee does not have the funds to purchase the item or service or the item/service is not available through another source.

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 IPOS and must be clearly linked to an assessed Enrollee need in the ICP.

Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of federal financial participation (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 ICP.

Where applicable, the Enrollee must use Medicaid State Plan, Medicare, or other available payers first. The Enrollee's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

For additional information on HCBS Waiver Individual Goods and Services provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.10. NON-MEDICAL TRANSPORTATION

Non-Medical Transportation (NMT) is offered to enable Enrollees to gain access to waiver and other community services, activities, and resources specified by the Integrated Care Plan (ICP). Whenever possible, the HIDE SNP shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. Need for this service and details as to whom and how it will be provided should be discussed in the person-centered planning meeting and documented in the ICP.

Direct service providers shall be a centrally organized transportation company or agency. Transportation may be provided by any of the following methods:

- 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:
  - Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the Enrollee.
  - Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.
- 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.
- 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.
- Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.

Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance. MICH funds may not be used to purchase or lease vehicles for providing transportation services to waiver Enrollees. All paid drivers for transportation providers supported entirely or in part by MICH 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. 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. Each provider shall operate in compliance with PA 1 of 1985 regarding seatbelt usage.

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

For additional information on HCBS Waiver NMT provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.11. PERSONAL EMERGENCY RESPONSE SYSTEM

The Personal Emergency Response System (PERS) is an electronic device that enables Enrollees to secure help in an emergency. The Enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the Enrollee's phone and programmed to signal a response center once a "help" button is activated.

The Federal Communication Commission (FCC) must approve the equipment used for the response system. The equipment must meet Underwriters Laboratories (UL) safety standards 1637 specifications for Home Health Signaling Equipment.

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

The provider must ensure at least monthly testing of each PERS unit to ensure continued functioning.

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

PERS is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The HIDE SNP 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.

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.

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

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.

The provider will furnish each responder with written instructions and provide training, as appropriate.

For additional information on HCBS Waiver PERS provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

1.2.B.12. PREVENTIVE NURSING SERVICES

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 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.

When the Enrollee's condition is unstable, could easily deteriorate, or when significant changes occur, the HIDE SNP 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 healthcare professional (such as the HIDE SNP Care Coordinator) to prevent additional decline, illness, or injury to the Enrollee. The HIDE SNP Care Coordinator shall communicate with both the nurse providing this service and the Enrollee's healthcare professional to ensure the nursing needs of the Enrollee are being addressed.

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 individual-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 ensure 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 healthcare professional.

In addition to 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 their medication regimen.
- Applying dressings that require prescribed medications and aseptic techniques.
- Providing refresher training to the Enrollee or informal caregivers to ensure 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 ADL, or safe ambulation within the home.

This service is limited to no more than two hours per visit.

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

All providers must be licensed in the State of Michigan as a RN or LPN. For additional information on HCBS Waiver preventative nursing services provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document.

1.2.B.13. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) services are skilled nursing interventions provided to an Enrollee age 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.

Medical Criteria

To be eligible for PDN services, the HIDE SNP 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.

- **Medical Criteria I** – The Enrollee is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
  - Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
  - Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
  - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
  - Total parenteral nutrition (TPN) delivered via a central line, associated with complex medical problems or medical fragility; or
  - 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 21 years of age 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.
- **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:

- "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.
- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "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.
- "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.
- "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 three or more ADL.
- "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:
  - "Continuous" means at least once every three 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.
  - "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:
    - 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;
    - 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;
    - Deep oral (past the tonsils) or tracheostomy suctioning;

- 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);
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, or is associated with complex medical problems or medical fragility;
- TPN delivered via a central line and care of the central line;
- 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 Enrollees age 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; and
- 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. All nurses providing 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. PDN may include medication administration according to MCL 333.7103(1).

This service must be ordered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner. The HIDE SNP is responsible for ensuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the HIDE SNP is responsible for ensuring the PDN provider has a copy of these orders and delivers PDN services according to the orders. The HIDE SNP shall maintain a copy of the physician orders in the Enrollees health record. The Enrollee's physician, physician's assistant, clinical nurse specialist, or nurse practitioner must order PDN services and work in conjunction with the HIDE SNP and provider agency to ensure services are delivered according to that order.

Through a person-centered planning process, the HIDE SNP shall determine the amount, scope and duration of services provided. The direct service provider shall maintain close contact with the authorizing HIDE SNP to promptly report changes in each Enrollee's condition and/or treatment needs upon observation of such changes. 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.

Enrollees receiving Preventive Nursing Services are not eligible to receive PDN services.

All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.

For additional information on HCBS Waiver PDN provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document.

1.2.B.14. Respite

1.2.B.14.1. Respite Provided at the Enrollee's Home or in the Home of Another Person

Respite 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 include:

- Attendant care (Enrollee is not bed-bound), such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
- Basic care (Enrollee may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Members of an Enrollee's family who are not the Enrollee's regular caregiver may provide respite for the regular caregiver. However, the HIDE SNP shall not authorize funds to pay for services furnished to an Enrollee by that person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the Enrollee.

Respite services cannot be scheduled on a long-term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. 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. The costs of room and board are not included in payment for respite services.

For additional information on HCBS Waiver Respite provider qualifications, refer to the MICH HCBS Waiver Requirements Resource Document.

Respite services are subject to Electronic Visit Verification (EVV) in accordance with the EVV chapter of this Manual.

1.2.B.14.2. Respite Provided Outside of the Home

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.

Each out-of-home respite service provider must be a licensed group home as defined in MCL 400.701ff which includes AFC homes and HFA. Respite may include the cost of room and board if the service is provided in a licensed AFC or licensed HFA.

Respite services include:

- Attendant care (Enrollee is not bed-bound), such as companionship, supervision and/or assistance with toileting, eating, and ambulation.
- Basic care (Enrollee may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

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.

For additional information on HCBS Waiver Respite provider qualifications, refer to the HCBS Waiver Requirements Resource document.

1.2.B.15. VEHICLE MODIFICATIONS

This service covers adaptations or alterations to a vehicle that is the Enrollee's primary means of transportation in order to meet the needs of the Enrollee. Vehicle adaptations are identified in the ICP as necessary to enable the Enrollee to engage in the community, and ensure health, welfare and safety of the Enrollee.

The vehicle that is adapted may be owned by the Enrollee, a family member with whom the Enrollee lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the Enrollee and is not a paid provider of such services.

The following are excluded:

- Adaptations or improvements to the vehicle that are of general utility and not of direct medical or remedial benefit to the Enrollee.
- Purchase or lease of the vehicle
- Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

The waiver agency and/or direct service provider must pursue payment by other sources, as applicable, before the waiver agency authorizes payment.

Payment may not be made to adapt vehicles that are owned or leased by paid providers of MICH services.

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.

For additional information on HCBS Waiver Vehicle Modifications provider qualifications, refer to the HCBS Waiver Requirements Resource document.

1.2.C. Hospice

MICH Enrollees who elect hospice services may remain Enrolled in the MICH program if they choose.

When a MICH Enrollee elects hospice services, the hospice agency must notify the Enrollee's HIDE SNP for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice services and other Medicare Part A and Part B services not related to the terminal illness and bill the HIDE SNP for room and board when hospice is rendered in a nursing home setting.

An Enrollee has the option of disenrolling from MICH at any time. During the month when disenrollment occurs, the Enrollee will remain with MICH until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MICH Enrollee enrollment status.

The HIDE SNP is responsible for paying room and board for Enrollees that receive hospice services in a long-term care (LTC) facility (i.e., NF, County Medical Care Facility (CMCF), hospital long term care unit). The HIDE SNP will receive the Tier 1 rate for Enrollees receiving hospice services in a LTC facility setting. The Tier 1 rate includes the room and board for the LTC facility. The HIDE SNP must coordinate with the hospice provider for payment. The HIDE SNP will pay the hospice provider the room and board, and the hospice provider will pay the facility. The HIDE SNP will make the QAS payments to the NF, even in cases when the hospice pays the room and board.

Additional information on Hospice Services is included in the MICH Hospice Resource Document. (Refer to the Directory Appendix for document location information.)

1.3 Coordination of Services Covered Outside of the SMAC

The HIDE SNP must provide information to the Enrollee regarding the availability of these services and coordinate care and benefits as appropriate.

- Inpatient hospital psychiatric services (refer to the Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and the Inpatient Hospital Psychiatric Services subsection of this chapter.)
- Outpatient partial hospitalization psychiatric care (refer to the Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and the Mental Health subsection of this chapter.)

- Behavioral health assessment and services for Enrollees meeting the guidelines under Medicaid policy for serious mental illness or severe emotional disturbance (refer to the Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and the Mental Health subsection of this chapter.)
- Certain substance use disorder (SUD) services (refer to the Directory Appendix for the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid and the Substance Abuse, Inpatient and Outpatient subsection of this chapter), including:
  - Assessment (per MDHHS policy, the HIDE SNP must reimburse SUD services provided in the office setting by a practitioner not Enrolled with or associated to a PIHP)
  - Detoxification (see the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid)
  - Intensive outpatient counseling and other outpatient services
  - Methadone treatment and other SUD treatment
- Services including, but not limited to, therapies (speech, language, physical, occupational) provided to persons with intellectual and/or developmental disabilities (I/DD) that are billed through PIHPs, CMHSP providers, or Intermediate School Districts
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility) after disenrollment
- Community Transition Services (CTS) offered by MDHHS
  - The HIDE SNP is responsible for making referrals to the CTS program when an Enrollee meets program criteria as defined in the Community Transition services chapter of this Manual.
- Children's Special Health Care Services (CSHCS) offered by MDHHS

1.4 Services Excluded from HIDE SNP Coverage but Covered by Medicaid

- MDHHS maintains a list of specific Medicaid program-covered physician-administered drugs and biological products that are not covered by HIDE SNPs. This list of physician-administered drugs and biological products, carved out from HIDE SNP coverage, will be reimbursed as a FFS benefit for all Enrollees in FFS and for those Enrolled in a HIDE SNP. However, if a drug included on the physician-administered drugs and biological products list is covered by Medicare, the HIDE SNP must provide coverage through Medicare, as required. (Refer to the Physician-Administered Drugs and Biological Products Not Covered by Medicaid Health Plans subsection of the Practitioner chapter of this Manual for additional information. Refer to the Directory Appendix for website information for the physician-administered drugs and biological products list.)
- Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid FFS Program.
- Services provided to an individual with Medicaid who resides in a State Veterans' Home.

1.5 SERVICES THAT HIDE SNPS ARE PROHIBITED FROM COVERING

HIDE SNPs are prohibited from using State funds to provide the following services:

- Elective cosmetic surgery
- Services for treatment of infertility
- Experimental/investigational drugs, biological agents, procedures devices, or equipment
- Elective abortions and related services
  - Abortions may be covered if one of the following conditions is met:
    - A physician certifies that the abortion is medically necessary to save the life of the mother.
    - The pregnancy is a result of rape or incest.
    - Treatment is for medical complications occurring as a result of an elective abortion.
    - Treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy.
    - All appropriate forms relating to abortion must be completed by the designated party and the HIDE SNP must retain these forms for 10 years. The appropriate forms must also be submitted to MDHHS annually and prior to reimbursement. Providers must follow policy in the Practitioner chapter of this Manual.

1.6 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. The HIDE SNP is permitted to use its own funds to pay for these fines, fees or taxes, if it chooses to do so if the issues are a barrier to providing services.

SECTION 2 – SPECIAL COVERAGE PROVISIONS

This section provides general information regarding HIDE SNP coverage requirements for certain services. Additional information regarding HIDE SNP requirements related to these services is contained in the HIDE SNP SMAC.

2.1 COMMUNICABLE DISEASE SERVICES

HIDE SNP must cover or pay applicable Medicare cost sharing for Enrollees to receive treatment services for communicable diseases from local health departments (LCDs) without prior authorization, including Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Sexually Transmitted Infections (STI), tuberculosis, and vaccine-preventable communicable diseases.

2.2 DENTAL SERVICES

Beneficiaries Enrolled in a HIDE SNP will receive their dental coverage through their HIDE SNP. Each HIDE SNP contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the HIDE SNP and the dental provider group or vendor, and Enrollees must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the Enrollee's HIDE SNP. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible Enrollee will not be reimbursed. For dental program coverage policy, refer to the Dental Chapter of this Manual.

2.3 EMERGENCY SERVICES

HIDE SNPs are responsible for emergency services, including medical screening exams, consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd (a)) and the Federal Balanced Budget Act of 1997. HIDE SNPs may not require prior authorization for emergency screening and stabilization services provided to Enrollees.

HIDE SNPs are not responsible for paying for non-emergency treatment services beyond screening that are not authorized by the HIDE SNP. Coverage for emergency services includes emergency transportation, hospital emergency room services, and professional services.

When Michigan Medicaid covers emergency services not covered by Medicare or covers a needed service in a greater amount, duration, or scope than Medicare, the HIDE SNP must provide these services through Medicaid in accordance with the SMAC.

- Under the SMAC, the HIDE SNP must cover appropriate cost sharing for Medicare-covered emergency services and medical screening exams consistent with EMTALA (42 USC 1395dd(a). Enrollees must be screened and stabilized without prior authorization.
- The HIDE SNP must ensure Emergency Services are available 24 hours per day and 7 days per week.
    - The HIDE SNP must cover appropriate cost sharing for Medicare-covered out-of-network or out-of-area Emergency Services and medical screening and stabilization

services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services.

- The HIDE SNP must cover appropriate cost sharing for Medicare-covered Emergency Services regardless of whether the emergency department provider or hospital notified the Enrollee's primary care provider (PCP) or the HIDE SNP of the Enrollee's services in the emergency department.
- Unless a n authorized/legal representative or guardian of the HIDE SNP or the Enrollee's PCP instructed the Enrollee to seek emergency services, the HIDE SNP will not be responsible for paying for or covering cost-sharing for non-emergency treatment services that are not authorized by the HIDE SNP.
- The HIDE SNP must cover appropriate cost sharing for Medicare-covered emergency transportation and professional services needed to evaluate or stabilize an emergency medical condition found to exist using a prudent layperson standard.

- Hospitals offering emergency services are required to perform a medical screening examination on emergency room Enrollees leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist.
- If an emergency medical condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the Enrollee.
- The HIDE SNP must ensure that emergency services continue until the Enrollee is stabilized and can be safely discharged or transferred.
- If any services are not covered by Medicare but covered by Medicaid, the HIDE SNP must cover such services under the SMAC.
- The HIDE SNP must cover (consistent with 42 CFR 422.214) appropriate cost sharing for Medicare-covered post-stabilization care services obtained within or outside the HIDE SNP's network that are pre-approved by the HIDE SNP provider or other HIDE SNP representative.
- The HIDE SNP must cover appropriate cost sharing for Medicare-covered post-stabilization care services, regardless of whether the services were provided in the HIDE SNP's network, even if these services were not pre-approved by the HIDE SNP provider or other HIDE SNP representative, but administered to maintain the Enrollee's stabilized condition within one hour of a request to the HIDE SNP for pre-approval of further post-stabilization care services.
- If an Enrollee requires hospitalization or other healthcare services that arise out of the screening assessment provided by the emergency department, then the HIDE SNP may require prior authorization for such services. Such services must be deemed prior authorized, and the HIDE SNP must cover appropriate cost sharing under any of the following conditions:
  - If the HIDE SNP does not respond within the timeframe established under 42 CFR 438.114 and 42 CFR 422.113 (one hour) to a request for authorization made by the emergency department.
  - If the HIDE SNP is not available when the request for post-stabilization services occurs.
  - If the HIDE SNP representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a HIDE SNP physician is not available for consultation. In this situation, the HIDE SNP must give the treating physician the

opportunity to consult with a HIDE SNP physician and the treating physician may continue with care of the Enrollee until the HIDE SNP physician is reached or one of the criteria specified below is met.

- The HIDE SNP's financial responsibility for Medicaid coverage or Medicare cost-sharing for post-stabilization care services not pre-approved ends when any of the following conditions are reached:
  - The HIDE SNP physician with privileges at the treating hospital assumes responsibility for the Enrollee's care.
  - The HIDE SNP physician assumes responsibility for the Enrollee's care through transfer.
  - The HIDE SNP representative and the treating physician reach an agreement concerning the Enrollee's care.
  - The Enrollee is discharged.

2.4 Family Planning Services

HIDE SNP Enrollees have full freedom of choice of family planning providers, both in-plan and out-of-plan. HIDE SNPs may not require prior authorization for family planning services, including the detection and treatment of STDs. HIDE SNPs may advise out-of-network family planning providers, including public providers, to communicate with PCPs once any form of medical treatment is undertaken.

2.5 Federally Qualified Health Centers (FQHCs)

HIDE SNP Enrollees may access services provided through a Federally Qualified Health Center (FQHC).

FQHC providers must obtain prior authorization from the HIDE SNP. However, the HIDE SNP may not refuse to authorize medically necessary services if the HIDE SNP does not have a FQHC in the network in the county. The HIDE SNP may require FQHC providers to share information and data with the HIDE SNP and to provide appropriate referrals to providers in the HIDE SNP's network.

2.6 Maternal Infant Health Program (MIHP)

MIHP services provided to MICH Enrollees are administered by the HIDE SNP as outlined in the Maternal Infant Health Program Chapter of this Manual. All MIHP services provided to HIDE SNP Enrollees are coordinated and reimbursed by the HIDE SNPs. Only MDHHS certified providers may deliver MIHP services to HIDE SNP Enrollees.

To maintain fidelity of the program and to facilitate compliance with the reporting requirements of PA 291 of 2012, it is the expectation that MIHP providers and HIDE SNPs will adhere to program components including, but not limited to: MDHHS program certification, the required professional qualifications of staff, and the use of MDHHS MIHP forms. HIDE SNPs must establish and maintain a Care Coordination Agreement (CCA) with MIHP providers for both in-network and out-of-network services.

Within one month of when the HIDE SNP determines a pregnant or infant Enrollee is eligible for MIHP services, the HIDE SNP must refer the Enrollee to an MIHP provider. HIDE SNPs are not required to refer

Enrollees to an MIHP provider if the Enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services.

HIDE SNPs work cooperatively with the local MDHHS office to maintain a referral protocol for those Enrollees who need the assistance of MDHHS Children's Protective Services. MIHP providers must work with the HIDE SNP and MDHHS Children's Protective Services to ensure appropriate care for HIDE SNP Enrollees. (Refer to the Maternal Infant Health Program chapter of this Manual for additional information.)

2.7 Behavioral Health

HIDE SNPs are required to provide behavioral health services not included under the Prepaid Inpatient Health Plan (PIHP) specialty services and supports benefit. The Non-Physician Behavioral Health Appendix of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies and procedures related to these outpatient behavioral health services. Services should be provided through appropriate providers within the service area and may include contracted CMHSP providers.

For specialty behavioral health needs, HIDE SNPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided to the Enrollee. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs. The HIDE SNP must maintain a Coordinating Agreement with applicable PIHPs, in accordance with the requirements of the SMAC.

2.7.A. Inpatient Hospital Psychiatric Services

The HIDE SNP, in accordance with 42 CFR §422.318, is required to provide coverage for Inpatient Hospital Psychiatric Services for the admission through discharge if the Enrollee is Enrolled at the time of the admission. HIDE SNP Enrollees admitted to state psychiatric facilities are disenrolled from MICH at the end of the month of the admission in CMS' enrollment system (MARx) and the day prior to the admission in CHAMPS. The HIDE SNP is required to provide coverage up to the Medicare maximum of 190 lifetime days.

HIDE SNPs are not responsible for the physician cost related to providing a psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the HIDE SNP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.

2.7.B. Access to Services for Enrollees with Behavioral Health Needs

2.7.B.1. Primary Care

The HIDE SNP must provide primary care training on evidence-based behavioral health service models for PCPs such as Screening, Brief Intervention and Referral to Treatment (SBIRT).

The HIDE SNP must ensure access to and reimburse for behavioral health screening services provided to Enrollees in primary care settings.

2.7.B.2. BEHAVIORAL HEALTHCARE

The HIDE SNP must ensure access to all behavioral health services covered under the SMAC to all Enrollees with behavioral health needs, in accordance with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid.

MDHHS reserves the right to modify the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid including, but not limited to, changing coverage responsibility for mental health services so that responsibility will be determined by the level of the Enrollee's needs rather than by the setting in which a service is provided.

2.8 NURSING FACILITY

For traditional Medicaid nursing facility (NF) days of care, the HIDE SNP must negotiate with NFs to establish rates.

It is the responsibility of the NF provider to collect the Patient Pay Amount (PPA) from Enrollees for traditional Medicaid nursing facility days of care and the HIDE SNP must reduce reimbursements to NF providers equal to the PPA amount each month.

The Quality Assurance Supplement (QAS) will be paid through a directed payment as approved by CMS through the 42 CFR § 438.6(c) preprint process. The QAS payment will be the HIDE SNP traditional Medicaid NF days of care multiplied by 21.76% of the variable cost component of the FFS 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. Details regarding the methodology for QAS payments can be found in the MICH QAS Resource Document (refer to the Directory Appendix for document location information), as well as the CMS Section 438.6(c) PrePrint.

The HIDE SNP is responsible for paying room and board for Enrollees that receive hospice services in a long-term care (LTC) facility (i.e., NF, County Medical Care Facility (CMCF), hospital long term care unit). The HIDE SNP will receive the Tier 1 rate for Enrollees receiving hospice services in a LTC facility setting. The Tier 1 rate includes the room and board for the LTC facility. The HIDE SNP must coordinate with the hospice provider for payment. The HIDE SNP will pay the hospice provider the room and board, and the hospice provider will pay the facility. The HIDE SNP will make the QAS payments to the NF, even in cases when the hospice pays the room and board.

The HIDE SNP must reimburse NF providers Medicaid co-insurance for days 21 through 100 of a skilled care or rehabilitation day. Since the HIDE SNP negotiates rates with their provider networks as determined by their contract in accordance with federal regulations (42 CFR 422.202[a][1]), the HIDE SNP coinsurance rates vary and do not always equal the Medicare Part A coinsurance rate.

The HIDE SNP must, as part of their skilled NF benefit, provide skilled nursing level of care in a LTC facility without a preceding acute care inpatient stay for Enrollees when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

The HIDE SNPs may delegate responsibility for the completion of the LOCD to the facility. Additional details can be found in the MICH LOCD Resource Document. (Refer to the Directory Appendix for document location information)

For more information on NF coverage policy, refer to the Nursing Facility chapter of this Manual.

2.8.A. Enrollees Transitioning from a Long-Term Care (LTC) Facility to the Community

In order to ensure Enrollees transitioning from a LTC facility to the community do not lose Medicaid coverage when they are no longer in a NF or Enrolled in the HCBS Waiver, the following must occur:

- The HIDE SNP should communicate with the Enrollee that the HIDE SNP needs to check with MDHHS for potential Medicaid eligibility problems if the Enrollee leaves the nursing facility.
- The HIDE SNP must send an encrypted emailing including the Enrollee's name and Medicaid ID to the appropriate MDHHS mailbox (MDHHS-MICH-Waiver@michigan.gov). The subject line should include "Transitioning" and should not include any Enrollee identifying factors.
- The HIDE SNP will receive notification from MDHHS for the Enrollee's eligibility. The HIDE SNP should complete the necessary assessments to determine if the Enrollee qualifies for the HCBS Waiver.
- If the Enrollee qualifies for the waiver and would like waiver services, the HIDE SNP 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 NF.

2.9 Out-of-Network Services

2.9.A. Professional Services

With the exception of the following services, HIDE SNPs may require out-of-network providers to obtain plan authorization prior to providing services to plan Enrollees:

- Emergency services (screening and stabilization)
- Family planning services
- Immunizations
- Communicable disease detection and treatment at LHDs
- Tuberculosis services
- Certain MIHP services (refer to the Maternal Infant Health Program chapter for additional information)

When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, the HIDE SNP will pay out-of-network providers at established MDHHS Medicaid fees in effect on the date of service.

2.9.B. Hospital Services

HIDE SNPs reimburse hospitals according to the terms of the contract between the HIDE SNP and the hospital. If a hospital does not have a contract with a HIDE SNP but has signed a hospital access agreement with MDHHS, the following conditions apply:

- The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to Medicaid Enrollees Enrolled in HIDE SNPs with which the hospital does not have a contract.
- HIDE SNPs agree to continue to use network-contracted providers when available and appropriate.
- The hospital will be entitled to payment by HIDE SNPs for all covered and authorized (if required) services provided in accordance with their obligations under the hospital's contract with the HIDE SNP.
- A rapid dispute resolution process will be available for hospitals and HIDE SNPs who are unable to achieve reconciliation solutions for outstanding accounts through usual means.
- HIDE SNPs reimburse out-of-network (non-contracted) hospital providers at the Medicaid FFS rates in effect on the date of service. The payment for inpatient stays includes the relevant Diagnosis Related Group (DRG) and capital costs.

Copies of the Hospital Access Agreement, HIDE SNP Obligations, and Rapid Dispute Resolution are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Hospitals that have signed the Hospital Access Agreement and the HIDE SNPs are required to abide by the terms and conditions of the Hospital Access Agreement.

2.9.C. Post-Stabilization Authorization Determinations

Non-contracted hospitals are required to obtain a patient post-stabilization authorization determination from the Enrollee's HIDE SNP prior to any treatment and after stabilization. A post-stabilization authorization determination refers to the process in which inpatient hospital admission or admission to observation status is authorized by the HIDE SNP after the Enrollee has been stabilized.

Hospitals are required to make and document all post-stabilization authorization requests by telephone call to the Enrollee's HIDE SNP prior to providing any treatment after stabilization. Hospitals must provide the HIDE SNP with all requested, necessary and current information, including the clinical status upon initial presentation, the clinical status after stabilization, and the initial treatment plan. This information must be provided in accordance with EMTALA. The HIDE SNP is required to respond to post-stabilization requests within one hour of receipt of the telephone call and may not require hospitals to make additional phone calls if the initial phone call included all necessary and

current clinical information. If the HIDE SNP does not respond within one hour, authorization for inpatient admission, payment and additional services is automatic.

Within one hour of the phone call in which the hospital provides the required clinical information noted above, the HIDE SNP must make an authorization decision which specifies the service authorized. The decision must be based on the information presented by the hospital at the time of the request rather than a list of pre-determined diagnoses that automatically authorize the Enrollee for admission to observation status and not admission to the inpatient hospital. The HIDE SNP may not indicate that observation or admission will be authorized depending upon the clinical outcomes, and the HIDE SNP may not subsequently reverse an authorization decision based upon the clinical outcomes or length of time the Enrollee remains in inpatient status. If the hospital and HIDE SNP are unable to reach agreement on an authorization decision at the time of the request, the hospital and the HIDE SNP must arrange a discussion between physicians in order to resolve the dispute.

The HIDE SNP SMAC requires HIDE SNPs to provide twenty-four (24) hour, seven (7) days-a-week availability for post-stabilization authorization requests. Hospitals may not wait until the next business day after stabilization to call for authorization. If the hospital does not call for authorization after stabilization, prior to providing additional services, the HIDE SNP may review the clinical record at the time of request for authorization or payment to determine if inpatient hospital admission or admission to observation status was clinically appropriate.

2.10 Pharmacy Services

For pharmacy services not covered by Medicare, the HIDE SNP must provide pharmacy services to Enrollees according to Medicaid policy and MDHHS-established protocol (refer to the Pharmacy chapter of this Manual for more information) and in accordance with 42 CFR 438.3(s) and the SMAC.

2.11 Substance Abuse, Inpatient and Outpatient

The HIDE SNP must provide all substance abuse services not provided by the PIHPs consistent with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid (refer to the Directory Appendix) and MDHHS Medicaid policy.

The HIDE SNP may provide services through contracts with PIHPs, CMHSP providers, or contracts with other appropriate Medicaid network providers.

Medicaid specialty services, including behavioral health, intellectual/developmental disabilities services and supports, and substance use services, must be provided by the PIHP in accordance with the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid (refer to the Directory Appendix). The HIDE SNP must provide information to the Enrollee regarding the availability of certain SUD services, including:

- Assessment (per MDHHS policy, the HIDE SNP must reimburse SUD services provided in the office setting by a practitioner not Enrolled with or associated to a PIHP)

- Detoxification (see the Medicaid Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid)
- Intensive outpatient counseling and other outpatient services
- Methadone treatment and other SUD treatment

2.12 Non-Emergency Medical Transportation

The HIDE SNP must provide non-emergency medical transportation (NEMT) to and from medically necessary Medicare services, Medicaid covered services, and Medicaid services covered outside of this SMAC in accordance with the SMAC, Medicaid policy, and the Non-Emergency Medical Transportation chapter of this Manual.

2.13 Tuberculosis Services

HIDE SNP Enrollees may obtain testing for tuberculosis from LHDs without HIDE SNP prior authorization. Treatment may also be provided by the LHD without prior HIDE SNP authorization and regardless of whether a contractual or coordinating relationship exists between the HIDE SNP and the LHD. In the absence of a contract or other coordinating agreement, HIDE SNPs will reimburse the LHD at Medicaid FFS rates in effect on the date of service.

SECTION 3 – ENROLLMENT PROCESS

The HIDE SNP must accept new enrollments, make enrollments effective, and limit involuntary disenrollments as provided in subpart B of 42 CFR 422 and the policies and procedures set forth in the SMAC.

The HIDE SNP must accept enrollments for all potential Enrollees, as described in this section, at any time without regard to physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for healthcare services.

The HIDE SNP must limit enrollment to HIDE SNP eligible populations as described in the General Information section of this chapter and the SMAC, thereby establishing and maintaining Exclusively Aligned Enrollment as defined in 42 CFR 422.2.

Enrollment into a HIDE SNP is voluntary. The individual selects the HIDE SNP in which they wish to enroll, using the HIDE SNP provider networks and drug formularies to assist in making choices.

After enrollment, Enrollees are issued an identification (ID) card that is specific to the MICH program. This ID card is used instead of the traditional Medicare and Medicaid ID cards, and identifies the name of the HIDE SNP responsible for coverage along with the MICH logo. Enrollees will be Enrolled in the benefit plan called HIDE SNP-MC which is a benefit plan specific to the MICH program. (Refer to the Beneficiary Eligibility chapter for additional information.)

Individuals who are Enrolled in the MI Choice waiver or the Program of All-Inclusive Care for the Elderly (PACE) may enroll in MICH voluntarily, but must disenroll from MI Choice or PACE before MICH enrollment is effective. MDHHS will assist in this process to ensure a smooth transition between programs. Individuals who are Enrolled in MI Choice or PACE and wish to enroll in MICH must call the HIDE SNP to start the enrollment process. The HIDE SNP must obtain a signed Acknowledgment Form at the time of enrollment from all individuals receiving services from MI Choice or PACE immediately prior to enrollment with the HIDE SNP. The Acknowledgment Form will be standardized and provided by MDHHS. The HIDE SNP must maintain copies of signed forms and make them available to MDHHS upon request. (Refer to the Directory Appendix for information regarding the Acknowledgement Form Resource Guide).

3.1 METHODS OF ENROLLMENT

The HIDE SNP can utilize a Medicare Advantage Agent or Broker. If the HIDE SNP uses agents and brokers or makes payments to third parties to sell its HIDE SNP plan, the HIDE SNP must adhere to all applicable Michigan laws and regulations related to the licensure and activities of agents and brokers and follow all requirements set forth in 42 CFR 422.2274 and 423.2274 as applicable.

The HIDE SNP must ensure brokers have access to trainings specific to LTSS.

3.2 DEEMED ENROLLMENT

The HIDE SNP must offer Enrollees who lose Medicaid eligibility a three-month deeming period of continued enrollment in the HIDE SNP to minimize risks and maximize continuity of care during periods of temporary Medicaid eligibility loss in accordance with § 422.52(d).

The HIDE SNP or its authorized agent must monitor Medicaid eligibility for deemed Enrollees using daily enrollment files (834 File) and enrollment and eligibility verification transactions (270/271 process) at least monthly.

- If an Enrollee regains Medicaid eligibility within the deeming period, MDHHS will notify the HIDE SNP via a daily 834 enrollment file and will reinstate the Enrollee in the HIDE SNP.
- Reinstatement in the HIDE SNP will only occur for months during the period of deemed enrollment that the Enrollee has regained full Medicaid.

The HIDE SNP will receive capitation payments for months the Enrollee's HIDE SNP coverage has been reinstated.

- Medicaid capitation payments for months where an Enrollee's HIDE SNP coverage has been reinstated for a previously deemed enrollment period that do not reflect Medicaid encounters for services rendered during the deemed period are subject to recoupment.
- The HIDE SNP must submit Medicaid encounters for services rendered during months of deemed enrollment once the Enrollee's coverage has been reinstated in the HIDE SNP.

3.3 DISENROLLMENT

Enrollees may choose to disenroll from MICH at any time. Disenrollment is effective on the first day of the following month.

3.3.A. ENROLLEE MOVES OUT OF SERVICE AREA

HIDE SNPs should follow applicable CMS and MDHHS guidance when an Enrollee moves out of the service area.

SECTION 4 – PROGRAM ENROLLMENT TYPES

For MICH Enrollees who are residing in a NF or CMCF, HDE SNP-NFAC or HDE SNP-CMCF program enrollment type (PET) codes will be updated in CHAMPS when the NF or CMCF completes the Nursing Facility Admission in CHAMPS. The HDE-CMCF or HDE-NFAC PET code will be removed upon the facility completing the NF discharge information in CHAMPS when the Enrollee is discharged from the facility.

Similarly, when a MICH Enrollee elects hospice services, the HDE-HOSW, HDE-HOSN, HDE-HOSH, or HDE-HOSC PET codes will be updated in CHAMPS when the hospice provider completes the Hospice Admission in CHAMPS. When the Enrollee expires or otherwise is discharged from hospice services, the hospice provider must complete the Hospice Discharge in CHAMPS, which then removes the hospice-related PET codes.

When the MICH Enrollee receives hospice services while residing in a NF or CMCF, the hospice provider must indicate the facility of residence on the Hospice Admission in CHAMPS so the HIDE SNP can receive the appropriate capitation rate.

SECTION 5 – CLAIMS, COPAYMENTS AND REIMBURSEMENT

HIDE SNP claim completion requirements must be consistent with MDHHS claim completion requirements as detailed in the Billing and Reimbursement chapters of this Manual.

5.1 COPAYMENTS

The HIDE SNP should follow copayment requirements as outlined in the SMAC.

HIDE SNP Enrollees have different copayment requirements through the HIDE SNP than through FFS. HIDE SNP Enrollees may have copayments including NF PAAs, Medicare Part D covered drugs.

Pursuant to Section 1932(b)(6), 42 USC § 1396u-2 (b)(6), and in accordance with 42 CFR §438.106, the HIDE SNP and all of its providers and subcontractors must not hold a member liable for coinsurance, copayments, deductibles, financial penalties, and in some cases Part D drugs based on the Medicare Low Income Subsidy (LIS) guidelines, or any other amount other than any patient pay towards NF care.

5.2 PAYMENT RESPONSIBILITY WHEN ENROLLMENT STATUS CHANGES

The HIDE SNP should refer providers to the Billing and Reimbursement chapters of this Manual for clarification of payment responsibility if a Medicaid or CSHCS Enrollee changes enrollment status during a course of treatment.

5.3 REIMBURSEMENT FOR NONCONTRACTED PROVIDERS

Reimbursement for providers who are contracted with the HIDE SNP is governed by the terms of the SMAC. HIDE SNPs are required to pay noncontracted providers at Medicaid FFS rates for all properly authorized, medically necessary services for which a clean claim is submitted. Noncontracted providers must comply with all applicable authorization requirements of the HIDE SNP and uniform billing requirements.

- For reimbursement of out-of-network Emergency Services or Urgent Care Services, as defined by 42 CFR §§ 424.101 and 405.400 and the SMAC, the healthcare professional is required to accept as payment in full by the HIDE SNP the amounts the healthcare professional could collect for that service if the Enrollee were Enrolled in original Medicare or Medicaid FFS.
  - The HIDE SNP must cover applicable Medicare cost sharing for such out-of-network emergency or urgent care services. However, the HIDE SNP is not required to reimburse the healthcare professional more than the healthcare professional's charge for that service.
  - The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 CFR §§ 412.105(g) and 413.76.

- A Section 1861(u) provider of services may be paid an amount that is less than the amount they could receive if the Enrollee were Enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the HIDE SNP in writing that they are billing an amount less than such amount.
- The HIDE SNP may authorize other out-of-network services to promote access to services and continuity of care.

- When out-of-network services are authorized and where the service would traditionally be covered under Medicare Fee For Service (FFS), the HIDE SNP will pay out-of-network healthcare professionals and Section 1861(u) providers of services the amount that providers could collect for that service if the Enrollee were Enrolled in original Medicare (less any payments under 42 CFR §§412.105(g) and 413.76 for Section 1861(u) providers), regardless of the setting and type of care.
- The HIDE SNP must cover applicable Medicare cost sharing for such out-of-network authorized services.
- When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, the HIDE SNP will pay out-of-network providers at established MDHHS Medicaid fees in effect on the date of service.
- Enrollees maintain improper billing protections. If Michigan Medicaid has not established a specific rate for the covered service, the HIDE SNP must follow Medicaid policy for the determination of the correct payment amount. Nothing in this chapter or the SMAC must restrict the right of the provider and the HIDE SNP to negotiate a lower rate of payment.

SECTION 6 – HIDE SNP RATES

6.1 GENERAL INFORMATION

Federal regulations (42 CFR 438.6) require rates paid by the State of Michigan to HIDE SNPs to be actuarially sound. The State of Michigan contracts with a certified actuary to develop actuarially sound rates for the HIDE SNPs. Under this methodology, the State's Actuary establishes a rate for each rate cell covered under MICH. As mandated by the federal requirement, the State's Actuary certifies these rates are actuarially sound. There is no federal requirement that rates be actuarially sound for a particular HIDE SNP.

Actuarially sound rates for HIDE SNPs are capitation rates means satisfying relevant federal requirements (42 C.F.R. Sec. 438.4[a]) and comport with generally accepted actuarial practices and regulatory requirements.

6.2 RATE CATEGORIES

In order to establish actuarially sound rates, MDHHS establishes separate rate cells. Rate cell classifications include:

- Nursing facility level of care
- Residing in a nursing facility
- Age
- Other classifications, or changes to the classifications cited above, as outlined in rate certification materials
- Any risk or acuity adjustment as outlined in rate certification materials

6.3 DATA METHODOLOGY

MDHHS has a generally consistent approach to the rate development and certification methodology. The approach incorporates the factors recommended by the American Academy of Actuaries, including the following criteria:

- Base utilization and cost data are derived from the population covered under the HIDE SNP SMAC to the extent that adequate accurate information on this population is available to the State's Actuary at the time of rate development and certification
- Base utilization and cost data are derived from the set of covered services under the HIDE SNP SMAC
- Completion and any identified credibility or data error adjustments as outlined in rate certification materials Adjustments may be made to smooth data and account for factors such as incomplete data
- Projected prospective utilization and cost per service rate trending
- Assumptions are based on the State Actuary's professional judgment regarding the appropriateness of adjustments to the base year data
- Any or criteria indicated in rate certification materials

6.4 Data Sources

The annual rate development methodology for the establishment of actuarially sound rates utilizes some or all of the following data sources:

- FFS data for individuals eligible for Medicaid
- Reported encounter data for the covered population
- Managed care capitation rates paid to the health plans serviced in the Medicare-Medicaid dually eligible (MME) and MI Choice managed care programs
- Other data sources, or adjustments to the data sources above, as indicated in the rate certification materials

6.5 Public Review of Data Methodology

MDHHS shall produce for public review a report that includes the proposed HIDE SNP rates, documentation of the rate development, and actuarial certification prior to formal submission to the federal government.

SECTION 7 – HIDE SNP PROVIDER ENROLLMENT

The HIDE SNP must ensure that all network providers that provide Medicare covered services do not appear on the CMS preclusion list in order to submit claims for reimbursement or otherwise participate in the Medicare program. The HIDE SNP must ensure that all network providers, including out-of-state network providers that provide Medicaid covered services, are screened and Enrolled in the Michigan Medicaid Program in compliance with 42 CFR § 438.602(b). Payment of a portion of a Medicare covered service by a HIDE SNP does not constitute a Medicaid covered service.

Typical providers are professional healthcare providers who provide healthcare services to Enrollees. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.

A list of currently allowed typical provider enrollment information is available on the MDHHS Provider Enrollment website. Providers not included on the allowed list are not required to enroll. The Provider Enrollment website is updated periodically. Any updates to the MDHHS Provider Allowed Enrollment lists will be subject to provider enrollment requirements. (Refer to the Directory Appendix for website information.)

Atypical providers are organizations that do not provide healthcare. Atypical providers may be Enrolled in CHAMPS or Bridges and do not perform medical services (e.g., Home Help, Non-Emergency Medical Transportation [NEMT], Adult Foster Care [AFC]). Atypical providers may submit HIPAA transactions, but they do not meet the HIPAA definition of a healthcare provider and may not have an NPI number.

- Note: Fiscal Intermediaries (FIs) and agencies providing services that require Electronic Visit Verification (EVV) (in MICH: State Plan personal care, respite, ECLS) are able to enroll in CHAMPS, but other atypical providers (aside from NEMT) do not have a pathway to enrollment (e.g., PERS providers do not enroll in CHAMPS). The HIDE SNP can refer to the HCBS Waiver MICH HCBS Waiver Requirements Resource Document for additional information on which atypical providers may be Enrolled.

MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide Medicaid Enrollees with emergency medical services. Payment for out-of-state, out-of-network medical services are subject to Medicaid policy and applicable health policies and procedures. (Refer to the Out-of-Network Services subsection of this chapter for additional information.)

Refer to the General Information for Providers chapter, Provider Enrollment section of this Manual for additional provider enrollment information.

SECTION 8 – CONTINUITY OF CARE

The HIDE SNP must maintain an Enrollee's current providers and amount, scope and duration of services at the time of enrollment. This includes prescription drugs and providers which are not part of the HIDE SNP's network.

MICH Enrollees must maintain their current Medicare and Medicaid providers, supports and services for the timeframes set forth in the table below. Transition requirements vary based on the service and population, in accordance with the requirements and timelines set forth in the tables below.

For Enrollees receiving services from the Habilitation Supports Waiver (HSW) and/or through the PIHP under the Michigan 1115 Behavioral Health Demonstration, the following continuity of care requirements apply to HIDE SNP services:

HIDE SNP Transition Requirements for HSW and Enrollees Receiving Services Through the PIHP Under the Michigan 1115 Behavioral Health Demonstration	
Provider Type	**Timeframe for Continuing Current Services**
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 180 calendar days. (HIDE SNP must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 calendar days from enrollment, whichever is sooner).
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
Vision and Dental	Must honor PAs when an item has not been delivered.
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 180 calendar days. The ICP must be reviewed and updated and providers secured within 180 calendar days of enrollment.

HIDE SNP Transition Requirements for All Other Enrollees	
Provider Type	**Timeframe for Continuing Current Services**
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 90 calendar days. (HIDE SNP must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 calendar days from enrollment, whichever is sooner).
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
Vision and Dental	Must honor PAs when an item has not been delivered.
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 90 calendar days.
Medicaid Nursing Facility Services	Enrollee may remain at the facility through contract with the HIDE SNP or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the Enrollee chooses to relocate.
Waiver Services	Maintain current providers and level of services at the time of enrollment for 90 calendar days unless changed during the Person-Centered Planning Process for services provided by the HIDE SNP HBCS waiver.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 90 calendar days. The ICP must be reviewed and updated and providers secured within 90 calendar days of enrollment. If the HIDE SNP fails to meet this requirement, the continuity of care period must remain in place until the requirement is met. The HIDE SNP can increase or reduce the amount of services during the continuity of care period if a reassessment is conducted utilizing the Personal Care Assessment and the ICP is reviewed and updated with Enrollee approval. Not applicable for Enrollees transitioning from the MI Choice program.

Enrollees in the Habilitation Supports Waiver will continue to receive waiver services through the PIHP. Waiver services will not change due to enrollment in the HIDE SNP.

The HIDE SNP will provide the State Plan Personal Care benefit to Enrollees.

For all other Enrollees, the following continuity of care requirements apply to HIDE SNP services:

- During the transition period referenced in the tables above, changes from the existing provider or reductions in the amount, scope and duration of services can only occur in the following circumstances:
  - The Enrollee requests a change;
  - The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid;
  - The HIDE SNP, CMS, or MDHHS identifies provider performance issues that affect an Enrollee's health and welfare; or
  - As described in the tables above.
- For MICH Enrollees that disenroll then return to the HIDE SNP, the HIDE SNP must allow a continuity of care period for personal care services. The HIDE SNP must continue services based on the personal care services received at the time of the disenrollment.
  - If the Enrollee did not receive personal care services external to the HIDE SNP during the period of HIDE SNP disenrollment, the Enrollee can be out of the HIDE SNP for three months OR as long as the Personal Care Assessment (PCA) has not expired, whichever is longest, to receive continuity of care.
  - If personal care services were received external to the HIDE SNP during the period of HIDE SNP disenrollment, the HIDE SNP must honor the most recent amount, scope and duration of the services received during the disenrollment unless one of the criteria referenced in this section are met.
  - The continuity of care period is as follows:
    - 180 days for Enrollees receiving services through the PIHP under the Michigan 1115 Behavioral Health Demonstration or Habilitation Supports Waiver.
    - 90 days for all other Enrollees.
- Any reduction, suspension, denial or termination of previously authorized services must trigger the required notice under 42 CFR §§ 438.404 and 422.568 which articulates the Enrollee's right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an Adverse Benefit Determination (either in whole or in part) on the appeal.

The HIDE SNP is required to review Medicare and Medicaid utilization data provided by CMS and MDHHS to determine which providers have existing relationships with Enrollees. Continuity of care protection is automatic for providers which are verified through utilization data to meet the prior relationship requirement.

The Enrollee must have a relationship with a provider to establish continuity of care. A relationship is deemed to exist in the following circumstances:

- **Specialists:** The Enrollee must have seen the specialist at least once within the 12 months prior to enrollment into a HIDE SNP for a nonemergency visit.
- **Primary Care Provider:** The Enrollee must have seen the primary care provider at least twice within the 12 months prior to enrollment into a HIDE SNP for a non-emergency visit.
- **Other Covered Providers:** The Enrollee must have received services from other providers within the previous 12 months prior to enrollment into a HIDE SNP.

If the HIDE SNP cannot determine if a relationship exists based on the available data, the HIDE SNP shall ask the provider and Enrollee to provide documentation of the visit from the medical record or proof of payment to establish the relationship. An attestation that a relationship exists is not sufficient.

The HIDE SNP must ask the Enrollee about any upcoming appointments to ensure agreements are in place with out-of-network providers. If data is not available to establish relationship with the Enrollee's provider, the Enrollee or their appointed/legal representative or guardian may request continuity of care. The Enrollee's out-of-network provider may also request continuity of care on behalf of the Enrollee. Requests for continuity of care should be made by contacting the HIDE SNP's Enrollee services department or the Enrollee's HIDE SNP Care Coordinator. Requests can be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the HIDE SNP.

Generally, HIDE SNPs must start processing a request for continuity of care within five working days after the request is received. The HIDE SNP has a maximum of 30 days to complete the request. However, if the Enrollee's medical condition requires more immediate attention (e.g., an upcoming appointment), the HIDE SNP must complete the request within 15 days. If there is a risk of harm to the Enrollee or rescheduling of the appointment would be required, the request must be completed within three days of the request. The HIDE SNP may verbally convey continuity of care approval with the requester and record such approval in the Enrollee's record.

If the criteria for the prior relationship (as outlined above) are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care request as long as the provider submits the request for payment within 30 days of the first date of service.

The HIDE SNP must cover services during the continuity of care period for providers that do not have documented quality of care concerns that would cause the HIDE SNP to exclude the provider based on state or federal requirements.

8.1 Pharmacy Transitions

HIDE SNPs are required to maintain current prescriptions for medications for 180 days if medications are not on the HIDE SNP's formulary unless directed otherwise by CMS and MDHHS. The Enrollee can ask the HIDE SNP to make an exception to cover a drug that is not on the HIDE SNP's formulary.

Part D transition rules and rights will continue as provided for in current law and regulation.

The HIDE SNP must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the HIDE SNP's formulary but require

prior authorization or step therapy under the HIDE SNP's Utilization Management rules). This transition process must be consistent with the requirements at 42 CFR § 423.120(b)(3).

All non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored for 90 calendar days after enrollment and will not be terminated at the end of 90 calendar days without advance notice to the Enrollee and transition to other services, if needed.

8.2 Nursing Facilities

Out-of-network NFs must be offered Single Case Agreements to continue to care for the Enrollee if the NF does not participate in the contractor's network and the Enrollee:

- Resides in the NF at the time of enrollment.
- Has a family member or spouse that resides in the NF.
- Requires NF care and resides in a retirement community that includes a NF.

This continuity of care protection is available as long as the Enrollee resides in the NF. Continuity of care in a NF is automatic. The Enrollee does not have to make a request for continuity of care. The HIDE SNP must refill prescriptions for Enrollees in a NF for a minimum of 91 days and the HIDE SNP must refill the drug multiple times during the first 90 days of enrollment, as needed. This allows the prescriber time to change the drugs to those on the drug list or ask for an exception.

8.3 Personal Care Providers

The HIDE SNP must allow choice of PCS providers, including non-financially responsible family members or friends, to provide the service if they meet the criteria to enroll in the HIDE SNP's network.

The HIDE SNP may enter into an agreement for non-agency personal care providers when a permissible exclusion is identified through a background check. The HIDE SNP may allow for this exclusion if the Enrollee is informed of the details of the permissible exclusion and agrees, in writing, to allow the person to provide personal care to the Enrollee during the continuity of care period. During this time period, the Enrollee can seek alternatives to receiving personal care services if the HIDE SNP does not continue the agreement beyond the required continuity of care period.

Under no circumstance must the HIDE SNP enter into an agreement if it is discovered the personal care services provider falls under the policy for mandatory exclusion from providing personal care services.

8.4 Other Providers

During the transition period outlined in the tables above, the HIDE SNP will allow Enrollees access to any provider seen by the Enrollee within the previous 12 months, as indicated in CareConnect360, or reported by the Enrollee or provider prior to transition, even if the provider is not in the HIDE SNP's network.

During the transition period, the HIDE SNP will advise Enrollees and providers if and when they have received care that would not otherwise be covered in-network.

On an ongoing basis, and as appropriate, the HIDE SNP must contact providers who provide services to HIDE SNP Enrollees but who are not members of the HIDE SNP's network to provide information on becoming in-network providers.

Continuity of care does not extend to DME providers or ancillary service providers (e.g. suppliers of medical supplies or laboratories). Although continuity of care does not extend to these types of providers, the HIDE SNP must still provide continuity of care for services and the HIDE SNP is responsible for finding an in-network provider to deliver services without disruption.

8.5 Transferring Care/Service Plans and Liabilities

The HIDE SNP must be able to accept and honor established care/service plans provided on paper or electronically transferred from FFS, PACE, another HIDE SNP or other plan when Enrollees transition with care/service plans in place until the ICP is developed.

The HIDE SNP must ensure timely transfer of an ICP, HRA, and any other data to support continuity of care to another HIDE SNP, FFS, PACE, or other plan when an Enrollee is disenrolling from the HIDE SNP.

If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under the SMAC is terminated, the HIDE SNP must arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. The HIDE SNP must maintain documentation of such transfer of responsibility of medical care or treatment.

For hospital stays that would otherwise be reimbursed under Medicare or the Michigan Medicaid Program on a per diem basis, the HIDE SNP will be liable for payment for any medical care or treatment provided to an Enrollee until the effective date of disenrollment.

For hospital stays that would otherwise be reimbursed under Medicare or the Michigan Medicaid Program on a DRG basis, the HIDE SNP will be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective date of disenrollment.

8.6 Transitions Prior to the End of the Transition Period

The HIDE SNP may choose to transition the Enrollee to a network specialist or LTSS provider before the end of the transition period only if all the following criteria are met:

- The HRA and additional assessments, if applicable, are complete;
- The ICP is developed with Enrollee input and includes a transition plan to be updated and agreed to with the new provider, as necessary; and
- The Enrollee agrees to the transition and ICP prior to the expiration of the transition period.

SECTION 9 – CARE COORDINATION AND PERSON-CENTERED PLANNING

The HIDE SNP must offer Care Coordination services to all Enrollees to ensure effective integration and coordination between providers of medical services and supplies, behavioral health, substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD), pharmacy, and LTSS.

The HIDE SNP must provide the full spectrum of integrated care following requirements of the SMAC, including coordinating care along the continuum of health and wellbeing.

The HIDE SNP must utilize these principles to maintain or improve the physical and psychosocial wellbeing of Enrollees through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum.

The HIDE SNP must also include an overarching emphasis on health promotion and disease prevention and must incorporate community-based health and wellness strategies with a strong focus on Health-Related Social Needs (HRSN) and the Social Determinants of Health (SDoH) into its Model of Care (MOC), creating health equity and supporting efforts to build more resilient communities.

The HIDE SNP must ensure that the Enrollee has a PCP appropriate to meet their needs.

The HIDE SNP will develop and implement a strategy that uses a combination of assessments, referrals, administrative claims data, etc. to help prioritize and determine the care coordination needs of each Enrollee.

The HIDE SNP is required to have a comprehensive MOC as required at 42 CFR 422.101(f) and in accordance with CMS and MDHHS guidance inclusive of the requirements described within the SMAC that has earned approval from the National Committee for Quality Assurance (NCQA).

The HIDE SNP will focus on providing services in the most integrated and least restrictive setting.

The HIDE SNP will have significant flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.

The HIDE SNP must exhaust the use of community-based services before utilizing institutional settings for LTSS.

When needed, the HIDE SNP must include an authorized/legal representative or guardian familiar with the needs, circumstances and preferences of the Enrollee when the Enrollee is unable to participate fully in or report accurately to the Integrated Care Team (ICT).

HIDE SNP will be required to use any MDHHS-required data sharing systems and processes to enable care coordination and continuity of care.

Care Coordination services will provide for:

- A person-centered, outcome-based approach, consistent with Medicare and Medicaid requirements and guidance;
- The opportunity for the Enrollee to choose arrangements that support self-determination;

- Appropriate access and sharing of information, compliant with all applicable information privacy and security rules including HIPAA;
- The Enrollee's right to determine the appropriate involvement of all care team members including, and not limited to, providers, family members, caregivers, and other informal supports in accordance with applicable privacy standards; and
- Medication review and reconciliation conducted at least annually, when there is a change in condition or transition between settings, and in alignment with CMS and Healthcare Effectiveness Data and Information Set (HEDIS) requirements.

9.1 Person-Centered Planning

Person-Centered Planning is a process for planning and supporting a person receiving services that builds on the Enrollee's desire to engage in activities that promote community life and that honor the Enrollee's preferences, choices, and abilities.

The Person-Centered Planning Process is led by the Enrollee and involves families, friends, authorized/legal representative or guardian, and professionals as they desire or require. The process must be conducted in-person unless the Enrollee declines the opportunity to participate in-person.

More information on Person Centered Planning is included in the MICH Person Centered Planning Resource document. (Refer to the Directory Appendix for document location information.)

9.2 Integrated Care Team (ICT)

Every Enrollee must have access to and input in the development of an ICT to ensure the integration of the Enrollee's medical, behavioral health, psychosocial care, HRSN, food security, and LTSS. If an Enrollee is unable to be reached or unwilling to participate in the creation of an ICT, then the HIDE SNP will demonstrate via documentation attempts to engage with the Enrollee to participate in the ICT.

Attempts to engage the Enrollee must be on different days of the week and at different times during the day, including times outside of standard work hours.

Contact attempts must be made using different communication mechanisms including, and not limited to, telephonic outreach, written and mailed communication materials, home visits, or Enrollee portal notifications for Enrollees who have created portal accounts.

The ICT will be person-centered, built on the Enrollee's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.

The ICT will honor the Enrollee's choice about their level of participation. This choice will be revisited periodically by the HIDE SNP Care Coordinator as it may change.

9.2.A. Integrated Care Team Members

The HIDE SNP Care Coordinator will lead the ICT. It will be the responsibility of the HIDE SNP Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members in accordance with The HIDE SNP 's NCQA-approved MOC.

Representatives from entities other than the HIDE SNP that provide services and supports to the Enrollee, when applicable, will be members of ICTs as determined by the Enrollee to encourage communication and collaboration between HIDE SNPs and other providers.

Membership will include the Enrollee and the Enrollee's chosen allies, including HIDE SNP Care Coordinator and PCP. Additional membership on the ICT may vary depending on the changing needs of the Enrollee.

PCPs may designate a licensed medical professional on their staff who has personal knowledge of the Enrollee's condition(s) and healthcare needs to provide input in place of the PCP.

- Family caregivers and natural supports
- Primary care nurse care manager
- Specialty providers
- Personal care providers
- Hospital discharge planner
- NF representative
- Others as appropriate

9.2.B. INTEGRATED CARE TEAM RESPONSIBILITIES

The role of ICT is to work collaboratively with the Enrollee and other team members. The HIDE SNP Care Coordinator is responsible to ensure the completion of these tasks. ICT members will:

- Ensure the ICP is developed, implemented, and revised according to the person-centered planning process and the Enrollee's stated goals, including making whatever accommodations are appropriate for Enrollees whose disabilities create obstacles to full participation with the ICT
- Participate in the person-centered planning process at the Enrollee's discretion to develop the ICP
- Collaborate with other ICT members to ensure the person-centered planning process is maintained
- Assist the Enrollee in meeting their goals
- Monitor and ensure that the ICT member's part of the ICP is implemented in order to meet the Enrollee's goals
- Ensure the Enrollee's record is updated as needed pertinent to the ICT member's role on the ICT
- Review assessment, test results and other pertinent information
- Address transitions of care when a change between care settings occurs

- Ensure continuity of care requirements are met, and
- Monitor for issues related to quality of care and quality of life.

The operations of ICTs will vary depending on the needs and preferences of the Enrollee.

- An Enrollee with extensive service needs may warrant periodic meetings with input from all ICT members
- An Enrollee with less intense needs may warrant fewer meetings with selected members of the ICT
- The HIDE SNP Care Coordinator is responsible for facilitating communication among the ICT members
- It is the responsibility of the HIDE SNP Care Coordinator to share an update regarding the outcome of each ICT meeting available to ICT members within 14 calendar days
- The ICT will adhere to an Enrollee's determination about the appropriate involvement of their medical providers and caregivers according to HIPAA and, for Enrollees in SUD treatment, federal regulations, and Michigan Medicaid policy.

9.2.C. HIDE SNP CARE COORDINATOR

HIDE SNP Care Coordinators must have the experience, qualifications and training, including MDHHS-required training, appropriate to the needs of the Enrollee, and the HIDE SNP must establish policies for appropriate assignment of HIDE SNP Care Coordinators.

HIDE SNP Care Coordinators must be culturally competent and have knowledge of: physical health, aging and loss, appropriate support services in the community, LTSS including State Plan personal care, NF, and HCBS options.

The HIDE SNP Care Coordinator must have knowledge of the MDHHS Medicaid Provider Manual, as well as current MDHHS and federal requirements related to care coordination, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, SUD, physical and developmental disabilities, issues related to accessing and using DME as appropriate, SDoH, HRSN, health equity, health disparities, available community services and public benefits, the long-term care ombudsman program, the HIDE SNP ombudsman program, quality ratings as applicable, and information about available options such as NFs, AFC, HFA, and other residential settings, applicable legal non-discrimination requirements such as the ADA, person-centered planning, cultural competency, and elder abuse and neglect.

The HIDE SNP Care Coordinator must be either a Michigan:

- Licensed registered nurse
- Licensed nurse practitioner
- Licensed physician's assistant
- Licensed Bachelor's prepared social worker

- Limited license Master's prepared social worker
- Licensed Master's prepared social worker
- Limited license Bachelor's prepared social worker, or
- Clinical Nurse Specialist

9.2.D. HIDE SNP Care Coordinator Training

The HIDE SNP must develop and implement a comprehensive training program for Care Coordination staff including trainings required by federal rules, MOC requirements, and MDHHS directed topic areas.

The HIDE SNP must ensure Care Coordinators receive training in accordance with the SMAC.

9.2.E. HIDE SNP Care Coordinator Responsibilities

The HIDE SNP Care Coordinator will be responsible for care coordination for each Enrollee. The Enrollee must be provided information on how to contact their Care Coordinator.

The HIDE SNP Care Coordinator will: conduct the HRA, ensure the Person-Centered Planning Process is complete, prepare the ICP, coordinate care transitions, and lead the ICT.

The HIDE SNP Care Coordinator will be responsible for the following activities which may not be delegated to other individuals unless specified. For activities that may be delegated, the HIDE SNP Care Coordinator must supervise the activity and be informed of the activity for the purpose of member and provider communications, including ICT discussions. Activities include:

- Support an ongoing Person-Centered Planning process.
- Assess clinical risk and needs, including HRSN and the impact of SDoH, by conducting an assessment process that includes a HRA and completion of or referral for additional assessments (as appropriate).
- Facilitate timely access to all Medicare- and Medicaid-covered services including, but not limited to, primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the Enrollee, including referrals to address any physical or cognitive barriers or referrals to the PIHP (scheduling appointments or transportation may be delegated).
- Make referrals to address any physical or cognitive barriers or referrals to the PIHP.
- Create and maintain an electronic Enrollee health record for each Enrollee to manage communication and information regarding referrals, transitions, and care delivery.
- Facilitate communication among the Enrollee's providers through the use of the care coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence (may be delegated).

- Ensure that the ICT is notified of the Enrollee's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable.
- Facilitate face-to-face and in-person meetings, conference calls, and other activities of the ICT as needed or requested by the Enrollee
- Facilitate direct communication between the provider and the Enrollee or the Enrollee's authorized/legal representative or guardian and/or family or informal supports as appropriate (may be delegated).
- Facilitate Enrollee and family education.
- Coordinate and communicate, as applicable, with First Tier, Downstream, and Related Entities (FDRs) and other external entities that provide services and supports to the Enrollee to ensure timely, non-duplicative supports and services are provided.
- Develop with the Enrollee and ICT, following the Person-Centered Planning process, an ICP specific to Enrollee needs and preferences, and monitor and update the ICP at least annually or following a significant change in needs or other factors.
- Facilitate referrals to community resources (e.g. housing, food, energy assistance programs) to meet ICP goals (may be delegated).
- Perform ongoing care coordination.
- Monitor the implementation of the ICP with the Enrollee, including facilitating the Enrollee's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up.
- Advocate with or on behalf of the Enrollee as needed to ensure successful implementation of the ICP.
- Support transitions in care when the Enrollee moves between care settings, including:
  - The HIDE SNP Care Coordinator will contact the Enrollee once notified of an emergency room visit to review discharge orders, schedule follow-up appointments, review any medication changes, and evaluate the need for revising the ICP to include additional supports and services to remain in or return to the community.
  - The HIDE SNP Care Coordinator will ensure immediate and continuous discharge planning, including electronic and verbal communication with the Enrollee and ICT members, following an Enrollee's admission to a hospital or NF. Discharge planning will ensure that necessary care, supports and services are in place in the community for the Enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the Enrollee has all necessary medications or prescriptions upon discharge, and conducting follow-up with the Enrollee and/or caregiver.
  - The Care Coordinator must make every effort to ensure that HCBS are in place upon hospital discharge to avoid unnecessary NF placements. The Care Coordinator must be able to arrange for expedited assessments and other mechanisms to ensure prompt initiation of appropriate HCBS. If the Enrollee is being discharged from a NF or hospital, the Care Coordinator must coordinate efforts with the NF social worker, discharge planner, CTS Transition Navigator when applicable, or other staff to ensure a smooth transition.

- Evaluating Section Q of the Minimum Data Set (MDS) for Enrollees currently in a NF and discussing options for returning to the community, revising the ICP and transitioning the Enrollee to the most integrated setting or making a referral to CTS when applicable.
- The HIDE SNP Care Coordinator will inform the Enrollee of their right to live in the most integrated setting, inform the Enrollee of the availability of services necessary to support their choices, and record the home and community-based options and settings considered by the Enrollee.
- Engage in other activities or services needed to assist the Enrollee in optimizing their health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status.
- Assist with the timely completion of the Medicaid eligibility redetermination process to prevent the loss of benefits (may be delegated).
- The HIDE SNP Care Coordinator will ensure appropriate assessments are conducted for Enrollees with identified LTSS needs. The HIDE SNP Care Coordinator must collaborate with the applicable PIHP coordinator or identified behavioral health representative as defined in the Coordinating Agreement between the HIDE SNP and the PIHP.
- If the Enrollee has need of LTSS, the HIDE SNP Care Coordinator will collaborate with the Enrollee's chosen LTSS representative(s), as applicable, when the Enrollee has received LTSS within the last 12 months or a new Enrollee request is identified as having potential need for LTSS.

9.2.F. Enrollee HIDE SNP Care Coordinator Assignments and Change Requests

The HIDE SNP must allow the Enrollee or their authorized/legal representative or guardian choice in HIDE SNP Care Coordinator.

The HIDE SNP must ensure every Enrollee has a HIDE SNP Care Coordinator with the appropriate experience and qualifications based on the Enrollee's assigned risk level and Enrollee needs (e.g. communication, cognitive, or other barriers).

The HIDE SNP must have a process to ensure that an Enrollee or their authorized/legal representative or guardian is able to request a change in their HIDE SNP Care Coordinator at any time, including a process for the transition from one HIDE SNP Care Coordinator to another.

The HIDE SNP must establish policies for appropriate assignment of HIDE SNP Care Coordinators to align with the Enrollee's known or expressed cultural, religious, linguistic, and ethnic preferences by considering the knowledge and experience of the HIDE SNP Care Coordinator.

The HIDE SNP must provide a timely written notice to an Enrollee or their authorized/legal representative or guardian when there is a change in their HIDE SNP Care Coordinator.

The Enrollee must be notified, in writing, within two weeks 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 Enrollee (also authorized/legal representative or guardian) requested changes and the HIDE SNP related changes.

9.2.G. HIDE SNP CARE COORDINATOR CASELOADS

There is a mandatory limit on Care Coordinator caseloads based on a point system:

- Each low-risk Enrollee = 2 points
- Each medium-risk Enrollee = 5 points
- Each high-risk Enrollee = 10 points

The caseload must not exceed 600 points per Care Coordinator.

The HIDE SNP must establish processes to minimize Enrollee reassignments as part of meeting Care Coordinator caseload limit requirements (e.g. assigning Enrollees so that Care Coordinators are not at or close to the maximum point limit).

This caseload limit is subject to review by MDHHS and may be modified from time to time.

Caseload limits include unable to reach and unwilling to participate Enrollees on Care Coordinator caseloads. The HIDE SNP must ensure adequate staffing to meet the needs of the program and Enrollees without exceeding MDHHS defined ratios.

The HIDE SNP Care Coordinator must maintain contact with Enrollees at the frequency specified in the SMAC, with more frequent interactions as appropriate based on the Enrollee's needs.

If the HIDE SNP is unable to comply with Care Coordinator caseload ratio requirements due to constraints posed by being located in a region with a county that is classified as Rural or Counties with Extreme Access Considerations (CEAC) by CMS, it may make a request for a rural exception. Requests for rural exceptions must be submitted to the HIDE SNP's contract manager and must include, at minimum, the following information:

- Overview of compliance issue
- Barriers keeping The HIDE SNP from compliance
- Steps taken to attempt to come into compliance
- Steps taken to mitigate effects of noncompliance on Enrollee

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

The HIDE SNP must regularly monitor and report Care Coordinator caseload data in accordance with MDHHS requirements.

9.2.H. Requirements for HIDE SNP Care Coordinators Who Serve Enrollees with HCBS Needs

In addition to meeting the basic Care Coordinator qualifications described above, Care Coordinators serving Enrollees with HCBS needs must:

- Have knowledge of HCBS, including familiarity with current CMS HCBS regulations
- Be familiar with the HIDE SNP waiver services and 1915c application requirements
- Be familiar with Self-Determination, including how to implement self-directed service arrangements
- Be familiar with HCBS settings requirements and processes to ensure compliance with requirements as detailed in the HIDE SNP 1915c waiver application
- Be able to provide information regarding the quality ratings and licensure status, if applicable, of available residential options
- Be knowledgeable about risk factors and indicators of and resources to respond to and report abuse, neglect, exploitation, and other critical incidents
- Have experience conducting LTSS needs assessments
- Have familiarity with the Nursing Facility Level of Care Determination (LOCD)
- Be knowledgeable about eligibility requirements for the HIDE SNP HCBS Waiver
- Be knowledgeable about the processes for HIDE SNP HCBS Waiver enrollment and disenrollment

The HIDE SNP will be responsible for providing, directly or contractually, the following HCBS Care Coordination services:

- An ongoing Person-Centered Planning process
- Assisting the Enrollee to take a lead role in the Person-Centered Planning process
- Providing information to the Enrollee and ICT
- Communicating and collaborating with the PIHP, CMHSP, or other BH providers as appropriate, when BH, SUD, or I/DD needs are identified in the HRA
- Participating in the assessment process as needed, including conducting the HRA specific to the Enrollee's needs
- Participating in the Enrollee's ICT
- Assisting in the development, with the Enrollee and the ICT, of an ICP
- Ensuring optimal utilization of information and community supports
- Arranging services as identified in the ICP
- Updating the Enrollee health record with current Enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery
- Monitoring service implementation, service outcomes, and the Enrollee's satisfaction

- Assisting the Enrollee during transitions between care settings, including full consideration of all options
- Advocating for the Enrollee and support self-advocacy by the Enrollee.

The HIDE SNP must ensure Enrollees contracted to conduct the Care Coordination activities meet the qualifications set forth in the Care Coordination section of the SMAC.

If HCBS Care Coordination activities set forth in the SMAC are sub-contracted, the sub-contracted care coordination activities must supplement and not supplant the role of the HIDE SNP Care Coordinator.

9.2.I. Coordination Tools

The HIDE SNP will employ a care coordination platform, supported by web-based technology, that allows secure access to information and enables all Enrollees and members of the ICT to use and (where appropriate) update information.

The HIDE SNP is required to share information with Enrollees, providers (including LTSS and BH providers), and other HIDE SNPs as appropriate through its care coordination platform.

To minimize the duplicate data entry burden on providers that have already invested in certified electronic health records and who have or will soon achieve meaningful use stage one, two, or three compliance, the HIDE SNP will also support automated electronic data exchange from providers using the Office of the National Coordinator (ONC) compliant protocols and formats.

The HIDE SNP's care coordination platform will:

- Manage communication and information flow regarding referrals, care transitions, and care delivery.
- Facilitate timely and thorough coordination and communication among HIDE SNP, the PCP, and other providers.
- Provide prior authorization information for services.

The approved electronic care coordination platform will generate and maintain an Enrollee health record including:

- Current integrated condition list
- Contact information for the HIDE SNP Care Coordinator and ICT members
- Current medications list
- The date of service and the name of the provider for the most recently provided services
- Historical and current utilization and claims information
- Historic Medicaid and Medicare utilization data provided by MDHHS, CMS, and other sources

- HRAs, additional assessments, and reassessments
- Service outcomes, including specialty provider reports, lab results, and emergency room visits
- ICP
- Notes and correspondence across provider settings

The care coordination platform will allow HIDE SNP Care Coordinators and providers to post key updates and notify ICT members.

The HIDE SNP will maintain the care coordination platform and address technological issues as they arise.

The HIDE SNP is responsible for granting and monitoring access to appropriate ICT members.

The HIDE SNP will provide ICPs and other items in the Enrollee health record in paper format to the Enrollee upon request.

The HIDE SNP will verify the accuracy of the Enrollee health record and amend or correct inaccuracies. Corrections or amendments must be dated and attributed to the person making the change.

The HIDE SNP will have a mechanism to alert ICT members of emergency department use or inpatient admissions using the electronic care coordination platform or other methods such as telephonic notification.

9.2.J. Health Promotion and Wellness Activities

The HIDE SNP must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other informal caregivers.

The focus and content of this information must be relevant to the specific health status needs, including HRSN as well as the common risk factors and SDoH that impact the dually Medicare Medicaid eligible population.

Health promotion and disease prevention services must be offered in a manner that is informed by the life experiences, personal preferences, desires, and cultures of the target population.

The HIDE SNP must ensure Enrollees have access to evidence-based/best practices educational and wellness programs.

Interpreter services must be available for Enrollees who are not proficient in English.

Examples of health promotion and wellness topics include, but are not limited to, the following:

- Chronic condition self-management

- Smoking cessation
- Nutrition
- Prevention and treatment of alcohol and substance use

SECTION 10 – ENROLLEE STRATIFICATION, ASSESSMENTS, AND INTEGRATED CARE PLAN (ICP)

The HIDE SNP will develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of care coordination needed by each Enrollee.

The HIDE SNP may also choose to use existing predictive modeling software to support the stratification process but is not required to do so.

Within 15 calendar days of enrollment, the HIDE SNP must review all available program level data and utilization data to assign initial risk stratification to prioritize outreach and to determine the need for in-person assessments and care coordination activities.

Initial and ongoing stratification decisions must be based on all available program level data, utilization data, and assessment data including and not limited to Enrollee demographics, physical, behavioral, LTSS, and other medical conditions, functional status, care patterns, resource utilization data, SDoH, HRSN, food security, and the Enrollee's risk for long term care institutionalization or avoidable hospitalization.

The following populations are automatically stratified as high risk:

- Enrollees receiving services in the Habilitation Supports Waiver
- Enrollees receiving services in the HIDE SNP HCBS Waiver
- Enrollees transitioning to the HIDE SNP from the MI Choice waiver
- Enrollees transitioning to the HIDE SNP from PACE
- Enrollees who are within their first 90 days in the HIDE SNP after transitioning from Home Help
- Enrollees who are transitioning from a NF to the community
- Enrollees who are receiving personal care services and meet NFLOCD but are not Enrolled in the HIDE SNP HCBS Waiver
- Enrollees with unmet needs due to low or no access to needed resources such as caregiver support, housing, food, transportation, and shelter
- Enrollees who have had five or more hospitalizations in the last 12 months related to uncontrolled conditions
- Enrollees who have had six or more emergency department visits within the last 12 months
- Enrollees who had a hospitalization or emergency department visit with a primary diagnosis related to behavioral health within the last 12 months, until the condition(s) has stabilized
- The HIDE SNP will determine the parameters and definitions for other Enrollees defined as high risk as well as definitions for low or moderate risk Enrollees.

10.1 Health Risk Assessments (HRAs)

Each Enrollee must receive, and be an active participant in, a timely HRA of medical, behavioral health, psychosocial, SDoH, HRSN, and LTSS needs completed by the HIDE SNP Care Coordinator using the standardized Health Risk Assessment Tool (HRAT) required by MDHHS unless an Enrollee chooses to decline an assessment. Should that occur, the HIDE SNP will honor and document the Enrollee's decision. Enrollee.

In instances where Enrollees are unable to be reached for ongoing assessments, the HIDE SNP will need to leverage available information (e.g. MDHHS 270/271 process, 834s, the Enrollee, CMS, other sources, etc.) to conduct outreach and document attempts. The HIDE SNP must attempt to reach the Enrollee at least three times within the first 90 days of enrollment.

- The HIDE SNP must continue to attempt to contact Enrollees who were classified as unable to reach after the first 90 days of enrollment.
- One contact attempt must be made at least monthly after the first 90 days. The contact attempts must be informed by claims data analysis and regular coordination with providers and FDR, which must also be conducted monthly.
- Telephonic outreach attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.
- Contact attempts must be made using different communication mechanisms including, and not limited to, telephonic outreach, written and mailed communication materials, home visits, or Enrollee portal notifications for Enrollees who have created portal accounts.
- Outreach attempts must be documented in the Enrollee's record.

The HIDE SNP must use community resources where possible to identify and engage Enrollees.

The HIDE SNP Care Coordinator will identify, through the HRA, Enrollees who may require institutional level of care and Enrollees with BH, SUD, and I/DD needs.

- The HIDE SNP will utilize the DSM-5 screening tool within the HRA to identify Enrollees with BH, SUD, and/or I/DD needs.
- When the results of the screening indicate a need for further follow-up, the HIDE SNP must make a referral to the PIHP within five days of identifying the need.
- If an Enrollee refuses a referral to the PIHP for additional evaluation, the HIDE SNP must document this in the Enrollee's health record.

The HIDE SNP must assist the Enrollee to remove barriers to the Enrollee's correct utilization of services and make the appropriate referrals to BH and SUD providers when appropriate.

The HIDE SNP will perform the HRA using the standardized HRAT provided by MDHHS to assess each Enrollee's current health, welfare, functional needs, SDoH impacts, HRSN, quality of life, strengths, supports, and risks.

The HIDE SNP may include additional MDHHS-approved questions and domains as appropriate.

The HIDE SNP will coordinate with the PCP to ensure that Enrollees with complex medical needs identified in the HRA have further follow-up relevant to these needs.

- The HRA will be completed by the HIDE SNP Care Coordinator employed or contracted with the HIDE SNP who is accountable for providing Care Coordination services.
- The HIDE SNP retains responsibility and accountability for utilization management functions, appeals, and approval of services.
- The Care Coordinator role cannot be delegated through contract or other means to LTSS providers who are otherwise responsible for providing services to Enrollees, such as NFs.

The HIDE SNP will invite the appropriate representative from the PIHP, entity providing LTSS, or NF staff as appropriate to participate in conducting the HRA if the Enrollee has been active in the PIHP or LTSS system during the previous 12 months or is currently residing in a NF.

- Family members or other individuals may also be included in the HRA process to the extent desired by the Enrollee.

The HIDE SNP is encouraged to conduct all assessments in-person and must conduct the HRA in-person for those Enrollees with immediate needs or stratified as high risk.

The HIDE SNP will use the results of the HRA to confirm the appropriate acuity or risk stratification level for Enrollee Care Coordination assignments and to determine the need for an additional assessment.

- The HRA and additional assessments, if applicable, will be used to develop the ICP.

The HIDE SNP will make referrals to PIHPs according to the process identified in its MDHHS-approved Coordinating Agreements for Enrollees identified as having BH, SUD, and/or I/DD needs.

The HIDE SNP will not refer Enrollees to PIHPs who are residing in a NF at the time of the HRAT completion who are identified with BH, SUD and/or I/DD needs and are receiving services through the Omnibus Budget Reconciliation Act (OBRA) PASRR program.

- If unmet needs are identified for this population, the HIDE SNP will coordinate needed care and service with NF staff and the local CMHSP responsible for the PASRR program and BH service delivery to Enrollees in the NF.
- The Enrollee will continue to receive any services in any existing care/service plan prior to completion of the HRA.
- The HIDE SNP will adhere to all transition requirements for services in order to ensure continuity of care, as described above, will be documented in the Enrollee's health record and results used in the development of the ICP.

10.2 Timing of Health Risk Assessments (HRAs)

HRAs will be completed within 90 calendar days of enrollment.

Enrollees identified with immediate needs or as having high risk must have HRAs completed earlier than 90 calendar days from enrollment, as appropriate.

The HIDE SNP Care Coordinator is responsible for ensuring completion of further assessment for Enrollees with medically complex conditions.

The HIDE SNP is prohibited from completing HRAs by mail. The HIDE SNP may mail HRAs only with prior approval from MDHHS.

The HIDE SNP Care Coordinator is encouraged to conduct the HRA in-person. Enrollees identified with immediate needs or as having high risk will have assessments completed in-person.

The HIDE SNP must ensure that a reassessment and an ICP update are performed:

- At least every 12 months after the HRA completion date.
- When there is a change in the Enrollee's health status or needs.
- As requested by the Enrollee, their caregiver or authorized/legal representative or guardian, or their provider if they feel there has been a functional/health change.

The HIDE SNP will analyze utilization data of all Enrollees monthly to identify acuity and risk level changes. Reassessments will be completed when utilization data indicates a significant change in the Enrollee's acuity and risk status. ICPs and interventions will be updated and documented in the Enrollee's health record.

The HIDE SNP must identify Enrollees through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, providers, community organizations and HIDE SNP personnel.

The HIDE SNP must notify PCPs of enrollment of any Enrollee who has not completed an HRA within the time period set forth above and whom the HIDE SNP has been unable to contact. The HIDE SNP must encourage PCPs to conduct outreach to these Enrollees and to schedule visits.

The HIDE SNP must collaborate with clinics, hospitals, or Urgent Care Centers to identify Enrollee contact information for Enrollees the HIDE SNP has not been able to contact.

10.3 Additional Assessments

Additional assessments will be conducted by appropriately trained and knowledgeable licensed health professionals who have experience working with individuals who have HCBS or LTSS service needs. The licensed health professional is not required to meet Care Coordinator credentials or other specified credentials, unless indicated otherwise.

Any additional assessment that may have been completed prior to enrollment by appropriately trained and licensed health professionals may be adopted if it is not past the reassessment date. The additional assessment must be reviewed to determine if it is complete, accurate and appropriate for the Enrollee's current status.

Adoption of additional assessments completed by appropriately trained and licensed health professionals utilizing other assessment tools which are not past the reassessment date is allowed as long as the assessment addresses the same domains identified in the corresponding required additional assessment.

Additional assessments will be conducted in-person as soon as the Enrollee's condition warrants and no later than 20 calendar days from the date the need for an assessment was identified by the HIDE SNP unless a different timeframe is identified by MDHHS.

- If an individual or entity external to the HIDE SNP will conduct the additional assessment(s), the HIDE SNP must make a referral to the individual or entity within five business days from the date the need for an assessment was identified by the HIDE SNP.

Additional assessments will be documented in the Enrollee's health record and results used in the development of the ICP.

The HIDE SNP will ensure that the following additional assessments are conducted as appropriate for Enrollees based on needs identified during the HRA.

- InterRAI (Resident Assessment Instrument) home care assessment (interRAI HC/iHC) for Enrollees needing waiver services (interRAI HC data must be electronically transmitted to the State as directed by MDHHS).
- The personal care assessment for Enrollees demonstrating ADL needs identified in the HRA, Enrollees transitioning from the Home Help program, Enrollees with personal care flag in CareConnect360, Enrollees with identified personal care need in other MDHHS data exchange, or Enrollees with a history of personal care services from another HIDE SNP.
- NF LOCD for Enrollees demonstrating NF level of care needs, including HCBS Waiver service needs identified during the HRA to determine eligibility for those services as well as Medicaid NF services.
- Other assessments as may be approved by MDHHS.

10.4 INTERRAI HC

InterRAI HC assessment data must be electronically submitted to MDHHS as directed for purposes including, but not limited to, the passive LOCD redetermination process detailed in the Nursing Facility Level of Care Determination chapter of this Manual.

10.5 PERSONAL CARE ASSESSMENT

The Personal Care Assessment (PCA) will be conducted, as necessary, to determine eligibility for State Plan Personal Care Services.

MDHHS will provide the HIDE SNP with the PCA tool specifications to determine time and task for the Enrollee.

The HIDE SNP will adopt any existing assessment tool and the time and task determined by that tool for an Enrollee transitioning from the Home Help program or another HIDE SNP.

MDHHS will make available the time, task, and provider details through CareConnect360 or other data exchange.

The HIDE SNP must comply with supplemental guidance related to Personal Care Services included in the MICH Personal Care Services Resource Document. (Refer to the Directory Appendix for document location information.)

10.6 Nursing Facility Level of Care Determination (LOCD)

The Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool must be conducted for all Enrollees according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in Medicaid policy (refer to the Nursing Facility Level of Care Determination chapter of this Manual) and additional guidance provided by MDHHS. For the MICH program only, the Nursing Facility Level of Care Frailty Review criteria will be applied at the time the LOCD is conducted for the Enrollee if the Enrollee does not meet LOCD criteria under Doors 1-7. Additionally, for the MICH program, the LOCD must be conducted by a Care Coordinator holding a credential as described in the HIDE SNP Care Coordinator subsection of this chapter.

In order to determine eligibility for HCBS Waiver or Medicaid NF services, the HIDE SNP will ensure that the LOCD tool is conducted as necessary for Enrollees demonstrating NF level of care needs identified in the HRA, for those Enrollees residing in a NF at the time of enrollment, and for those Enrollees Enrolled in the HIDE SNP HCBS Waiver.

- The entity completing the tool will record the findings in CHAMPS for MDHHS to make final eligibility determinations and authorize appropriate tier assignment and the HIDE SNP Capitation Payment.
- Final eligibility determinations for LOCD will be completed by MDHHS or by an independent contracted entity, as directed by MDHHS.

The HIDE SNP must ensure compliance with the requirements for persons authorized to conduct the LOCD located in the Nursing Facility Level of Care Determination chapter.

- A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee through a verification review (LOCD-VR) to determine if the LOCD was conducted properly according to policy and resulted in the correct determination of eligibility.
- The entity that conducted the LOCD is required to submit all relevant documentation used to support the LOCD in a timeframe and manner directed by MDHHS.
- MDHHS or its designee will review every HIDE SNP LOCD door 0 (does not meet criteria for doors 1-8), make the determination of eligibility and issue an Adverse Benefit Determination Notice and appeal rights to the Enrollee as applicable.
- If an Administrative Appeals Hearing is required, the HIDE SNP will be notified and required to participate as a witness.

The HIDE SNP must ensure compliance with supplemental guidance related to LOCD located in the Nursing Facility Level of Care Determination chapter.

Additional information on NF LOCD requirements is included in the MICH LOCD Resource Document. (Refer to the Directory Appendix for document location information.)

10.7 Timing of the LOCD Tool

The LOCD must be conducted before the provider is eligible for Medicaid reimbursement for services rendered to the Enrollee.

- The LOCD must be conducted prior to or on the day of NF admission or HCBS Waiver enrollment.
- LOCD must be conducted and entered in CHAMPS by the first day of the NF stay.
- HCBS Waiver materials must be submitted to MDHHS via CHAMPS within 30 days of the LOCD being conducted by the HIDE SNP.
- If the Enrollee resided in a NF at the time of enrollment or initial HRA, an existing LOCD may be adopted. The HIDE SNP must ensure that the existing LOCD reflects the Enrollee's present condition. If the existing LOCD does not reflect the Enrollee's present condition, the HIDE SNP must ensure a new LOCD is conducted. The Freedom of Choice (FOC) form must be completed when adopting an LOCD if there is a change in program/provider or a new admission/enrollment.
- The LOCD is associated with the Enrollee rather than the provider serving the Enrollee. Therefore, if a Enrollee is seeking admission to or enrollment in a program and has a current LOCD in CHAMPS, the provider may adopt that LOCD to confirm functional eligibility. Refer to the Nursing Facility Level of Care Determination chapter for additional information.

10.8 Door 0 Process

When a HIDE SNP 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. The HIDE SNP will continue to complete sections 1 and 2 of the Freedom of Choice form at the time they conduct the LOCD.

The HIDE SNP must continue to upload all supporting documentation in CHAMPS at the time of submission of a Door 0 LOCD. MDHHS will review every Door 0 and make the determination of eligibility. MDHHS will enter a new LOCD after each review whether they find the Enrollee to be eligible or ineligible. If MDHHS determines the Enrollee is ineligible based on the information submitted, MDHHS will enter a new Door 0 into CHAMPS which will inactivate the HIDE SNP entered Door 0. MDHHS will provide Notice and Hearing Request to the Enrollee, and the HIDE SNP and MDHHS will be copied. All three parties would be notified and required to participate in any Administrative Hearing as witnesses. If MDHHS determines that the Enrollee is eligible based on the information submitted, MDHHS will complete and enter a new LOCD into CHAMPS which will inactivate the HIDE SNP Door 0 LOCD. Michigan Peer Review Organization (MPRO) will mail a letter to the HIDE SNP and copy MDHHS indicating that the Enrollee was found eligible. The HIDE SNP will be able to check the status of any Door 0 they have submitted in CHAMPS (keeping in mind the two-business day turnaround time.) The HIDE SNP must adopt the eligible LOCD by conducting the FOC form with the Enrollee. The HIDE SNP should refer to the Freedom of Choice Form subsection of the Nursing Facility Level of Care Determination chapter for additional instructions on completion of the FOC.

The Enrollee may request a secondary review. If a secondary review is requested when MDHHS was the initial reviewer, a different MDHHS reviewer will complete the second review of the LOCD than who completed the first review. The HIDE SNPs Door 0s may also still be selected through the system for verification review.

The LOCD review timeframe for verification review is two business days.

10.9 Reassessments

The HIDE SNP is responsible for ensuring that an annual reassessment for each Enrollee (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within 12 months of the last HRA.

If prior to the annual reassessment the Enrollee experiences a major change impacting health status, the HIDE SNP is required to reassess the Enrollee and review and revise the ICP with members of the ICT as needed.

The HIDE SNP is responsible to complete a reassessment as often as desired by the Enrollee and update the ICP with members of the ICT as needed.

The HIDE SNP is responsible for developing a reassessment strategy that includes conducting State defined reassessments. The HIDE SNP is encouraged to conduct all reassessments in-person and must conduct reassessments in-person when required by MDHHS.

Additional assessments will be repeated according to the timeframe indicated in the MICH Assessments Overview Resource Document. (Refer to the Directory Appendix for document location information.)

For Enrollees receiving NF LOC services or 1915(c) waiver services, the reassessment must confirm that the Enrollee continues to meet the Michigan Medicaid LOCD standards. If the standards are not met, the HIDE SNP will initiate planning for transitioning the Enrollee to more appropriate supports and services, including making a referral to the CTS program as applicable

Reassessments will be documented in the Enrollee's health record and results used in the development of the ICP.

10.10 Care Planning

10.10.A. Integrated Care Plan (ICP)

The HIDE SNP Care Coordinator, the Enrollee, their family, caregiver or authorized/legal representative or guardian, providers, and other ICT members must develop a comprehensive, person-centered, written ICP for each Enrollee. The HIDE SNP must use a standardized template for ICPs that will be developed and approved by MDHHS and the HIDE SNP. Unless the Enrollee refuses, the meeting to develop the ICP will be conducted in-person at a time and location convenient to the Enrollee.

If the Enrollee refuses the ICP, at a minimum the HIDE SNP Care Coordinator must provide their contact information to the Enrollee and re-visit the refusal at the time of reassessment or a change of condition.

If the Enrollee is unable to be reached or unwilling to participate in the ICP development, then the HIDE SNP will create an ICP using pertinent available information. All refusals must be documented in the Enrollee's health record.

The HIDE SNP must complete the initial ICP within 90 calendar days of enrollment. The HIDE SNP must attempt to reach the Enrollee at least three times within the first 90 days of enrollment for completion of the ICP.

- Attempts must be made on different days of the week and at different times during the day, including times outside of standard work hours.
- Contact attempts must be made using different communication mechanisms including, and not limited to, telephonic outreach, written and mailed communication materials, home visits, or Enrollee portal notifications for Enrollees who have created portal accounts.
- Outreach attempts must be documented in the Enrollee's health record.

Existing person-centered service plans or plans of care can be incorporated into the ICP. The HIDE SNP must review the adopted plan with the Enrollee to determine if revisions are necessary to address the Enrollee's prioritized goals and meet the Enrollee's needs. The ICP must be signed by the Enrollee and the Enrollee's assigned Care Coordinator. The ICP must be contained in the Enrollee's health record and shared with the Enrollee and the ICT.

10.10.B. ICP MONITORING

The HIDE SNP will review the ICP with the Enrollee to ensure it continues to meet the Enrollee's needs and is updated accordingly. Refusals to participate in the ICP review and the reason for the refusal must be documented in the Enrollee's health record.

The HIDE SNP must review ICPs of high-risk Enrollees with the Enrollee at least every 30 calendar days.

For Enrollees who have been designated high-risk, the HIDE SNP Care Coordinator will complete an in-person visit with the Enrollee to review the ICP at least quarterly.

- Other monthly ICP reviews during each quarter may be conducted as an in-person, telephonic or face-to-face visit with the Enrollee.

The HIDE SNP must review ICPs of moderate-risk Enrollees with the Enrollee at least every 90 calendar days.

- At minimum, at least every other ICP review will be an in-person visit with the Enrollee. The other quarterly ICP reviews may be conducted as an in-person, telephonic or telepresence visit with the Enrollee.

The HIDE SNP must review ICPs of low-risk Enrollees with the Enrollee at least every 180 calendar days.

- The Enrollee must be offered the opportunity for an in-person ICP review with the HIDE SNP Care Coordinator.
- If the Enrollee does not wish to have an in-person ICP review, the HIDE SNP Care Coordinator may conduct a face-to-face or telephonic visit with the Enrollee.

- The HIDE SNP Care Coordinator will discuss with the Enrollee the Enrollee's options for ICP reviews (in-person, telephone, face-to-face meetings). The HIDE SNP must document these discussions in the Enrollee's health record.

The HIDE SNP must update the Enrollee's ICP at least annually, and more frequently if conditions warrant or if an Enrollee requests a change.

The ICP must:

- Focus on supporting the Enrollee to achieve personally defined goals in the most integrated setting
- Be developed following MDHHS principles for person-centered planning outlined in this chapter and the MICH Person Center Planning Resource Document.
- Include consideration of the Enrollee's cultural values and the communication needs and preferences of the Enrollee
- Include the Enrollee's preferences for care, services, and supports
- Include the Enrollee's prioritized list of concerns, goals and objectives, and strengths
- Include specific providers, supports and services, including amount, scope, and duration
- Include a summary of the Enrollee's health status
- Include the plan for addressing concerns or goals and measures for achieving the goals
- Include person(s) responsible for specific interventions, monitoring, and reassessment
- Include the due date for the interventions and reassessment
- Include a plan to address SDoH and HRSN, including food security as necessary, identified in the HRA
- Be signed by the Enrollee and the Enrollee's assigned Care Coordinator.

The HIDE SNP must comply with supplemental guidance related to ICP content and signature requirements within this chapter and the MICH ICP Signature Guidance Resource Document. (Refer to the Directory Appendix for document location information.)

The HIDE SNP must implement person-centered planning in accordance with the Person-Centered Planning Guidelines Resource Document. (Refer to the Directory Appendix for document location information.) The person-centered planning process must include coordination of services between settings of care which includes appropriate discharge planning for short- and long- term hospitalizations.

SECTION 11 – SELF-DETERMINATION

The HIDE SNP will offer Enrollees the opportunity to use arrangements that support Self-Determination for appropriate waiver services.

The HIDE SNP will establish and submit policies and procedures to MDHHS that develop and implement mechanisms for Enrollees to access arrangements that support Self-Determination consistent with MDHHS requirements and guidance.

These policies and procedures will include provisions to:

- Inform the Enrollee of their right to use arrangements that support Self-Determination and document the Enrollee's decisions regarding these arrangements
- Reflect current statutory, policy and regulatory requirements related to arrangements that support Self-Determination, including the authority to control an individual budget (with the assistance of a FI) and the right to employ (hire, manage and, when necessary, terminate) workers and contracts with providers
- Make personnel available to help inform, navigate, connect, and refer to the Enrollees who are using arrangements that support Self-Determination.

HCBS Waiver Enrollees must be informed of the option to self-direct their own services when applicable. The Care Coordinator must ensure Enrollees are informed of the option to self-direct their services when their ICPs are created or updated.

Explanations of the Self-Determination option must:

- Make clear that self-direction of services is voluntary, and that Enrollees can choose the extent to which they would like to self-direct their services
- Provide the options to select self-directed supports or services
- Provide an overview of the supports and resources available to assist Enrollees to participate to the extent desired in self-direction
- HIDE SNP must report to MDHHS on a regular basis, in a format determined by MDHHS, the number of Enrollees utilizing self-direction; and the types of services being provided in self-directed arrangements.

Self-Determination provides MICH HCBS Waiver Enrollees the option to direct and control certain waiver services. For those MICH HCBS Waiver Enrollees who choose to participate in arrangements that support self-determination, the Enrollee (or chosen representative(s)) has decision-making authority over providers of waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring
- Hiring/firing staff
- Verifying staff qualifications
- Obtaining criminal history review of staff

- Specifying additional service or staff qualifications based on the Enrollee's needs and preferences so long as such qualifications comply with those described in the 1915(c) waiver application approved by CMS, and any additional guidance provided by MDHHS
- Specifying how services are to be provided and determining staff duties consistent with service guidelines as indicated in the CMS-approved waiver application and additional guidance provided by MDHHS
- Determining staff wages and benefits, subject to State and federal limits and budgets, if applicable
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff from providing services
- Reallocating funds among services included in the Enrollee's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Budget development for Enrollees using arrangements that support self-determination occurs during the person-centered planning process and is intended to involve any persons chosen by the Enrollee. Planning for the Enrollee's ICP precedes the development of the Enrollee's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. An Enrollee's budget is not authorized until the Enrollee and the HIDE SNP have agreed to the amount and its use. In the event that the Enrollee is not satisfied with the authorized budget, they may reconvene the person-centered planning process. FI services are available through the waiver to help Enrollees more fully exercise control over their services.

At any time, the Enrollee may modify or terminate the arrangements that support self-determination.

The Enrollee, their chosen allies, the HIDE SNP Care Coordinator and LTSS Supports Coordinator must all work together to identify challenges and address problems that may be a barrier to a successful self-determination arrangement. The decision of an Enrollee to terminate participation in self-determination does not alter the supports and services identified in the ICP. When the Enrollee no longer wishes to participate in self-determination, the HIDE SNP must assume responsibility for ensuring the provision of those services through its network of contracted provider agencies while still maintaining and honoring the Enrollee's choice of providers to the extent possible.

The HIDE SNP may terminate self-determination for an Enrollee when problems arise due to the Enrollee's inability to effectively direct supports and services. Prior to terminating a self-determination agreement (unless it is not feasible), the HIDE SNP informs the Enrollee in writing of the issues that have led to the decision to terminate the arrangement. The HIDE SNP will continue efforts to resolve the issues that led to the termination.

Additional information on Self- Determination is included in the MICH Self-Determination Implementation Technical Advisory Resource Document. (Refer to the Directory Appendix for document location information.)

SECTION 12 – CRITICAL INCIDENT REPORTING

The HIDE SNP must report critical incidents to MDHHS and other authorities as required by CMS and the State.

12.1 TYPES OF CRITICAL INCIDENTS THAT NEED TO BE REPORTED

HIDE SNPs must report the following:

- Exploitation
- Illegal activity in the home
- Medication errors
- Neglect
- Physical abuse
- Provider no shows
- Restraints, seclusion, or restrictive interventions
- Sexual abuse
- Suspicious or unexpected death
- Theft
- Verbal abuse
- Worker consuming drugs or alcohol on the job
- Suicide attempt

Additional guidance on Critical Incident Reporting is included in the MICH Critical Incident Resource Document. (Refer to the Directory Appendix for document location information.)

SECTION 13 – MI COORDINATED HEALTH HCBS WAIVER ENROLLMENT AND PERSON-CENTERED PLANNING

13.1 HCBS WAIVER ENROLLMENT

For active HIDE SNP Enrollees who meet criteria for HCBS Waiver services and have a documented need in their ICP, the HIDE SNP must submit HIDE SNP HCBS Waiver enrollments and disenrollments directly in CHAMPS in accordance with MDHHS expectations. CHAMPS user information and guidance can be found in the HCBS CHAMPS user guide. (Refer to the Directory Appendix for document location information). Waiver enrollment is limited to a certain number of Enrollees that has been approved by CMS.

Additional information on the requirements of HCBS enrollment submissions are included in the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

13.2 PERSON-CENTERED PLANNING

The person-centered planning process and ICP for MICH HCBS Waiver Enrollees must be compliant with the HCBS Final Rule (CMS-2249F; CMS- 2296-F) released by CMS on January 16, 2014. At a minimum, the ICP must include the following components:

- The HIDE SNP must develop the ICP before providing services.
- The Enrollee must approve of all services in the ICP.
- The HIDE SNP must document Enrollee approval and participation on the ICP, including:
  - Enrollee's preferences for care, services, supports, residential settings, and non-residential settings.
  - Supports and services options that were discussed with the Enrollee and their (or authorized/legal representative's or guardian's) choice of those services and providers.
  - When the Enrollee selects controlled residential settings such as licensed AFC or HFA, the following must be included in the ICP:
    - The chosen setting.
    - The Enrollee's resources.
    - Whether or not the Enrollee chooses to have a roommate as well as any specific preferences for roommates, bathroom schedules, etc.
    - Preference for engaging in community activities outside the home, and whether or not the Enrollee needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen.
    - Personal safety risks and any interventions that may affect the Enrollee's ability to engage in community activities outside the home without supervision.

        - Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an Enrollee's assessed needs; indicate established timeframes for periodic review of these modifications.
    - Enrollee's health and safety risks.
    - Enrollee's prioritized list of concerns, goals and objectives, strengths.
    - Summary of the Enrollee's health status.
    - The plan for addressing concerns or goals, actions for achieving the goals, and specific providers, supports and services, including amount, scope and duration.
- The Enrollee's (or authorized/legal representative's or guardian's) rights and choices of specific providers (and alternative providers, if necessary).
- A contingency (backup) plan for providers in the event of unscheduled absence of a caregiver, severe weather, or other emergencies.
    - Person(s) responsible for specific monitoring, reassessment, and evaluation of health and well-being outcomes.
    - Enrollee's informed consent.
    - Due date for interventions and reassessment.

The ICP clearly identifies the types of services needed from both paid and non-paid providers of supports and services. The amount (units), frequency, and duration of each waiver service to be provided are included in the ICP. The Enrollee chooses the supports and services that best meet their needs and whether to use the option to self-direct applicable services or rely on a HIDE SNP Care Coordinator and/or other supports coordinator to ensure the services are implemented and provided according to the ICP. When an Enrollee chooses to participate in arrangements that support self-determination, information, support and training are provided by the HIDE SNP Care Coordinator and/or other supports coordinator and others identified in the ICP and according to the MICH Self-Determination Implementation Technical Advisory (Refer to the Directory Appendix for document location information.) When an Enrollee chooses not to participate in self-determination, the HIDE SNP Care Coordinator or other supports coordinator ensures that supports and services are implemented as planned. The HIDE SNP Care Coordinator and/or other supports coordinators, as applicable, oversee the coordination of State Plan and waiver services included in the ICP. This oversight ensures that waiver services in the ICP are not duplicative of similar State Plan services available to or received by the Enrollee.

An electronic method of signing off on required documents such as the person-centered service plan is acceptable. When this method is utilized, the signature must be newly obtained each time the signature is required. The electronic signature cannot be stored and re-used at will.

In-person visits are valued as a means to support the health and welfare of Enrollees as well as integration into the community. All assessments and reassessments, and at least one monthly contact a quarter, are to be completed in-person. If the Enrollee has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, care coordination contact and activities may be made via a HIPAA-compliant virtual method (video only) in lieu of in-person during the quarantine or isolation period only. If assessments are completed via virtual method (audio and video only; cannot be only audio) 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. Additionally, the Enrollee's privacy must be protected during virtual visits. Video recording is not allowed. The HIDE SNP should support Enrollees 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.

13.3 Home and Community-Based Residential and Non-Residential Settings

The HCBS Final Rule (CMS-2249F; CMS-2296-F) applies to 1915(c) waiver programs. The HIDE SNP must comply with the HCBS Final Rule Federal Register, CMS webinars, and other information regarding the rule. Refer to the Home and Community Based Services chapter of this Manual for additional information on the requirements for Residential and Non-Residential Settings.

13.4 HCBS Provider Reviews

The HIDE SNP is responsible for conducting monitoring of waiver service providers to ensure compliance with provider qualifications and standards. The HIDE SNP is responsible for ensuring provider compliance prior to delivery of service and annually thereafter. The HIDE SNP completes monitoring reviews on all new providers prior to delivery of service. The HIDE SNP ensures, 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 ensure the provider meets qualification requirements for the delivery of MICH services and confirm provider has active licenses and certification), that all providers can continue to meet the applicable qualifications and standards. Additionally, the HIDE SNP must 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 MICH 1915c Waiver Application.

A complete Provider Monitoring Plan is included in the MICH HCBS Waiver Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

SECTION 14 – ENCOUNTERS

The HIDE SNP must submit to MDHHS complete and accurate Medicare and Medicaid Encounter Data in the form and manner described in 42 CFR 438.818 and the SMAC including, but not limited to:

- Companion guides/data clarification documents
- Electronic file layout instructions
- Encounter reporting presentations

Encounter data reporting requirements are posted on the MDHHS website.

Additional guidance on Encounter requirements is included in the MICH Encounter Requirements Resource Document. (Refer to the Directory Appendix for document location information.)

SECTION 15 – CRIMINAL HISTORY REVIEWS

Each HIDE SNP and direct provider of home-based services must conduct a criminal history review, at a minimum, for any paid or volunteer individuals who will be entering the Enrollee's residence. The HIDE SNP and direct provider must have completed reference and criminal history reviews before authorizing the person providing services in an Enrollee's residence. At a minimum, the scope of the reference and criminal history investigation is statewide.

HIDE SNPs and MDHHS will conduct annual reviews to ensure mandatory criminal history reviews have been conducted in compliance with direction given by MDHHS or otherwise required by federal and state law, policy or operating standards.

SECTION 16 – USE OF RESTRAINTS, SECLUSION, AND RESTRICTIVE INTERVENTIONS

Providers are prohibited from using methods of seclusion, restraint, and/or other restrictive interventions. MDHHS will conduct site reviews to ensure these methods are not used. HIDE SNP Care Coordinators and LTSS Supports Coordinators, as applicable, have the primary responsibility for identifying and addressing the use of seclusion, restraints, and/or restrictive interventions.

SECTION 17 – PROVIDER PARTICIPATION

Providers have the opportunity to participate in MICH by joining the provider networks of the HIDE SNPs. HIDE SNPs are encouraged to contract with existing service providers for Enrollees eligible for and enrolling in the program to ensure continuity of care. Likewise, service providers are encouraged to participate in HIDE SNP networks to provide choice, continuity of care and high quality service. The HIDE SNP is responsible for authorizing and paying for Medicare and Medicaid services. Additional information regarding how providers may participate in MI Coordinated Health can be found on the MI Coordinated Health website. (Refer to the Directory Appendix for website information.)

SECTION 18 – DIRECT CARE WORKER PROVIDER PAY INCREASE

Pursuant to the SMAC, the HIDE SNP shall increase its 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 HIDE SNP 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 SMAC and the 438.6(c) preprint.

SECTION 19 – MEDICAID POLICY

Current and future Medicaid policies are applicable to the Medicaid portion of the MI Coordinated Health benefit package unless otherwise specified in this chapter or other policies or guidance.

SECTION 20 – QUALITY ASSURANCE

HIDE SNPs must comply with requirements set forth in the SMAC, MI Coordinated Health waiver applications approved by CMS, and any other supporting documentation.

SECTION 21 – TRAINING

The HIDE SNP is responsible to ensure all training requirements are met in accordance with the SMAC.

SECTION 22 – APPEALS

The SMAC establishes individual notice and appeal rights that must be adhered to when any grievable or adverse action is taken by the HIDE SNP or contracted entities that would fall under the grievance or appeals processes available to Enrollees through Medicare and Medicaid guidelines.

The HIDE SNP must honor oral requests for appeal. When a HIDE SNP receives an oral request for a standard (i.e., non-expedited) appeal, it should send the Enrollee confirmation of the appeal (including facts, reason for appeal, etc.) in writing. HIDE SNPs should not wait for the Enrollee 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 the SMAC.

SECTION 23 – OMBUDSMAN

HIDE SNPs and providers must work with the Ombudsman to resolve enrollment and service issues. HIDE SNPs must provide Ombudsman contact information in their Enrollee materials.

DIRECTORY APPENDIX

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS INFORMATION	INFORMATION AVAILABLE/PURPOSE
MI COORDINATED HEALTH (MICH)			
HCBS CHAMPS User Guide		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to HCBS waiver enrollments and disenrollments in CHAMPS
Non-Residential Setting Survey Template		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Setting Survey
Residential Settings Survey Template		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Setting Survey
MICH Acknowledgement of Exclusions Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information regarding provider exclusions
MICH Acknowledgement Form		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Form required for individuals transitioning from MIC or PACE
MICH Acknowledgement Form Resource Guide		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Resource guide for Acknowledgement Form
MICH Assessment Tools Overview		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information about program assessment requirements
MICH Critical Incidents Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information about critical incidents
MICH Encounter Requirements Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to encounter requirements
MICH Home Delivered Meals Service Guidelines Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Home Delivered Meals Guidelines
MICH Hospice Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to hospice
MICH ICP Signature Requirements Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Guidelines for ICP Signatures

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS INFORMATION	INFORMATION AVAILABLE/PURPOSE
MICH Personal Care Services Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to state plan personal care services
MICH Person Centered Planning Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	PCP Guidelines
MICH QAS Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to QAS
MICH Self Determination Implementation Technical Advisory		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	SD implementation guide
MICH Settings Resource Guidance		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to HCBS settings
MICH HCBS Waiver Services Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to HCBS waiver
MICH LOCD Resource Document		https://www.michigan.gov/mdhhs/doing-business/providers/mi-coordinated-health/information-for-health-plans-and-providers	Information related to NFLOCD