DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

January 14, 2025

Meghan Groen
Senior Deputy Medicaid Director
Michigan Department of Health & Human Services
Behavioral Health and Physical Health and Aging Services
400 S. Pine Street
P.O. Box 30479
Lansing, MI 48933

RE: 1915(c) Michigan's Children's Waiver Program Waiver Renewal Control #: MI.4119.R07.00

Dear Deputy Director Groen:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to renew Michigan's Children's Waiver Program, MI.4119.R07.00, which serves individuals with Intellectual Disabilities or Developmental Disabilities or both, that meet an ICF/IID level of care. The CMS Control Number for the renewal is MI.4119.R07.00 and should be referenced on all future correspondence relating to this waiver renewal.

For this HCBS waiver, you have requested a waiver of 1902(a)(10)(B) of the Social Security Act to waive comparability of services. The waiver has been approved for a five-year period with an effective date of October 1, 2024.

This waiver will offer the following supports for waiver participants:

1. Respite
2. Specialized Medical Equipment & Supplies
3. Environmental Accessibility Adaptations
4. Therapeutic Activities
5. Vehicle Modification
6. Financial Management Services
7. Community Living Supports
8. Home Care Training, Family
9. Non-Family Home Care Training
10. Overnight Health and Safety Support

The following number of unduplicated recipients and estimates of average per capita cost of waiver services have been approved:

Waiver Year	C Factor Estimates	D Factor Estimates	D' Factor Estimates	G Factor Estimates	G' Factor Estimates
Year 1	669	$ 32155.18	$ 15196.00	$ 81108.00	$ 4631.00
Year 2	669	$ 34936.53	$ 16566.00	$ 83136.00	$ 4747.00
Year 3	669	$ 36336.77	$ 17229.00	$ 85214.00	$ 4865.00
Year 4	669	$ 37888.90	$ 17973.00	$ 87344.00	$ 4987.00
Year 5	669	$ 39305.35	$ 18635.00	$ 89528.00	$ 5112.00

This approval is subject to your agreement to serve no more individuals than those indicated in "C Factor Estimates" shown in the table above. If the state wishes to serve more individuals or make any other alterations to this waiver, an amendment must be submitted for approval. The state may renew the waiver at the end of the five-year period by providing evidence and documentation of satisfactory performance and oversight.

It is important to note that CMS approval of this waiver solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state's spending plan.

In accordance with 42 CFR 423.910, states submit Medicare Modernization Act (MMA) files to CMS to, among other things, ensure that dually eligible individuals have the correct cost sharing amounts for the Medicare Part D prescription drug coverage. Participants in 1915(c) waivers qualify for $0 copays for Medicare Part D drugs. To ensure cost sharing is accurate, it is imperative that the state apply the "H" indicator on MMA file submissions for all Medicare-eligible participants in this waiver. This indicator is what initiates $0 copays for Medicare Part D drugs. More information is in chapter 6 of the MAPD State User Guide.

Thank you for your cooperation during the review process. If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Krystal Duffy at krystal.chatman@cms.hhs.gov or (410) 786-5235.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

cc: Keri Toback
Mark Halter
Lynell Sanderson

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

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

Michigan is removing Enhanced Transportation as a service due to limited utilization, and adding Equine Therapy under "Specialty Services" to the Children's Waiver Program (CWP) array of covered services. Transportation is a State Plan service which will cover this service for children on CWP as well. Therefore, there will be no loss or reduction of services.

For Specialty Services, providers will no longer be required to have full board certification before providing services. This will expand the provider network for these services and allow more beneficiaries to receive services. Providers would be required to be under the appropriate supervision while pursuing board certification to maintain a high quality of this service being provided.

Michigan is changing eligibility language for Overnight Health and Safety Support to allow more beneficiaries to access this service.

The CWP is also adding 100 additional slots which will change from 569 to 669 slots.

"Fiscal Intermediary" has been updated to "Financial Management Services" for consistency of language. The service specifications have not changed.

We aligned verification for staff credentialing from every 2 years to every 3 years to provide administrative consistency and efficiencies. Many of our waiver provider agencies provide services outside of the waiver and this aligns with their certification requirements.

Prepaid Inpatient Health Plans (PIHP)/ Community Mental Health Services Programs (CMHSPs) site reviews has been changed from biennial to annual site reviews.

Conflict Free Access and Planning requirements have been included in the application surrounding beneficiary service planning activities and service provision.

Performance measures and the sampling methodology were updated in response to CMS feedback.

Since the last renewal in 2019, MDHHS went through a reorganization. The Medicaid Services Administration (MSA) who had responsibility for operations and payments went through a reorganization and is now the Behavioral and Physical Health and Aging Services Administration (BPHASA). Additionally, a new bureau was created with a focus on children's specialty behavioral health services at this time. The administration, operation, and oversight of the 1915(c) waivers is now shared across two bureaus: the Bureau of Specialty Behavioral Health Services (BSBHS) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). BPHASA and BCCHPS continue to operate under MDHHS. Throughout the waiver application, MDHHS will be used to collectively capture BPHASA and BCCHPS involvement with the Children's Waiver Program.

Pursuant to Section 12006(a) of the 21st Century Cures Act, Michigan continues to actively pursue successful implementation of Electronic Visit Verification (EVV) within all applicable waivers and state plan services, including the CWP, for in-scope Personal Care Services (as defined by the Cures Act) that require an in-home visit by a provider. Michigan has selected the Open Vendor model and has executed a contract with a vendor to provide a State sponsored EVV solution. Michigan’s current contract allows providers to either use the State sponsored EVV solution as their primary method of EVV reporting, or an alternate approved EVV systems. Michigan’s EVV solution is designed to collect all 6 required data elements including the type of service performed, individual receiving the service, date of the service, location of the service delivery, individual providing the service, and the time the services begins and ends. Michigan’s EVV system also includes a pre-billing component that supports only clean claims being successfully adjudicated/processed. The CWP is scheduled to go-live with EVV implementation by September 2024, and MDHHS remains committed to ongoing compliance beyond that date. Current in-scope services for CWP include Community Living Supports and Respite services.

The MDHHS transition plan includes waiver renewal webinars for the PIHPs and CMHSPs to cover updates and answer questions prior to implementation. Waiver Support Application (WSA) training will also continue.

MDHHS is not using funding from section 9817 of the American Rescue Plan Act of 2021 (ARP) for the implementation of the changes under this amendment. However, because MDHHS accepted section 9817 for other purposes within the broader department, MDHHS is still subject to the Maintenance of Eligibility requirements for the Medicaid program.
MDHHS covers children from birth to 21 who are medically needy via the state plan via 435.322. This population is also included in the eligibility groups that may receive waiver services.

1. Request Information (1 of 3)

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

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

Children's Waiver Program

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.4119
Waiver Number:MI.4119.R07.00
Draft ID: MI.012.07.00

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

Regular Waiver

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

10/01/24

Approved Effective Date: 10/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **section 1915(b)(2) (central broker)**

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

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

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

1115 Behavioral Health Waiver Demonstration

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

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

2. Brief Waiver Description

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

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

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

Oversight of the CWP is provided by the Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. The administration, operation, and oversight of the 1915(c) waivers is shared across two teams: the Behavioral and Physical Health and Aging Services Administration (BPHASA) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS), both which reside in MDHHS. The CWP is a Managed Care program administered locally by Prepaid Inpatient Health Plans (PIHPs) under contract with MDHHS. Services are provided by the PIHP, its affiliate Community Mental Health Services Programs (CMHSPs) if applicable or its contracted entities. Services are provided directly by PIHPs, their contracted providers and/or providers of the beneficiary's choice through Financial Management Services under Choice Voucher arrangements and Purchase of Service contracts. When medically necessary, CWP beneficiaries may receive any of the Mental Health State Plan services and waiver services identified in Appendix C of this §1915(c) renewal waiver application. Beneficiaries enrolled in the CWP may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

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

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

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

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

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

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

○ **Not Applicable**

○ **No**

◉ **Yes**

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

◉ **No**

○ **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

(3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

Prior to decisions being made regarding changes for the 1915(c) waiver renewals, MDHHS solicited community partners and public feedback through a variety of avenues between May and December 2023. MDHHS presented at the Self-Determination Conference and Annual Waiver Conference. MDHHS also held a series of waiver feedback meetings with internal and external community partners. The meetings were widely distributed to invite multiple community/public groups, including MDHHS staff, PIHP/CMHSP staff, community partners, advocacy groups, and families. The goal of the feedback meetings was to discuss current waiver services, processes, and operations, and gather feedback on suggested changes to each of these areas. Feedback was also received through scheduled meetings with internal MDHHS staff and external partners, as well as via email on an ongoing basis. The consolidated feedback was discussed in depth with MDHHS waiver staff to begin drafting potential changes for the waiver renewal.

MDHHS sent a Tribal notice on 05/01/2024 to provide an opportunity for Tribal members to review the waiver applications and submit comments. The period of Tribal comment ended 06/17/2024. The general public notice/comment period was 05/17/2024-06/19/2024.

Non-electronic public notice:
Public notice was released via several of the major newspapers statewide on 05/17/2024. The newspaper notice included the website where the applications were posted as well as the email address and mailing address where comments and requests could be submitted.
The website where the waiver applications were posted for review and comment is:
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/medwaivers

Responses to specific comments are addressed below:

COMMENT: Page 28, Autism is listed as “Target Group” for CWP. Will Autism-specific charts (i.e., BHT, EPSDT be reviewed again or is this only if they are also enrolled in CWP?
RESPONSE: This is not a new requirement. There will be no additional related reviews.

COMMENT: Performance Measure: Number and percent of completed Individual Plans of Service (IPOS) that reflect provider separation of service planning from service delivery. Numerator: Completed IPOS that reflect provider separation of service planning from service delivery. Denominator: All completed IPOS.
How will this process measure be gathered?
RESPONSE: Thank you for your feedback. MDHHS is considering all input as we continue to develop the Conflict-Free Access and Planning requirements and relevant timeline for implementation.

COMMENT: Concern regarding ability for certain areas of the state to provide massage therapy due to limited providers with current proposed credentialing criteria. Suggest removing national credentialing criteria to expand provider pool to provide this service.
RESPONSE: MDHHS will review national credentialing requirements for massage therapy to determine if adjustments can be made to align with the credentialing requirements, similar to other activity therapies (Music, Art, Rec therapy).

COMMENT: Thank you for the additional slots, however more are needed.
RESPONSE: Thank you for the support and comment.

COMMENT: Regarding increase of Waiver slots to 669: Will there be additional slots added over the next four years?
RESPONSE: Yes, that is correct. MDHHS goal of requesting the addition of 100 slots is to increase MDHHS overall capacity to serve children/youth on the waiver.

COMMENT: Regarding state limiting number of participants served in a Waiver year: Recommendation to set a threshold to ensure priority of invitation to those with highest needs/highest scores.
RESPONSE: That is our current practice; children are invited based on their score from the Pre-Screen. Those with the highest scores are invited first. The CWP is not first come first serve.

COMMENT: The CWP offers necessary services and supports beyond what is available under the Medicaid State Plan to beneficiaries with developmental disabilities whose needs have placed them at risk for health, safety and/or out-of-home placement. This does not specify that the individual cannot have Medicaid to be eligible for CWP; this distinction should be made clear in the document.
RESPONSE: This is correct, the language does not state this. At this time, we will not be changing the language in the

application. It is the intention that MDHHS will continue to serve children on the waiver who do not have access to Medicaid. CMS has given the MDHHS the ability to determine (broad authority) to set policy to meet the needs of our State.

COMMENT: Page 44 regarding Performance Measure: Should this be ICF/IID level of care instead of State Psychiatric Hospital level of care? Or does this mean placement in inpatient was made prior to enrolling in the CWP? The assumption here is that State Psychiatric Hospital replaces ICF/IID level of care since there is no ICF/IID level of care in Michigan.
RESPONSE: Thank you for your comment. Yes, you are correct ICF/IID level of care is what we use for CWP. We will review the language in the application for accuracy.

COMMENT: Initial enrollments only require Waiver Certification form to be uploaded to WSA. Is it the expectation that the PIHP review LOC evaluations outside of the WSA process?
RESPONSE: The Level of care evaluation is determined by information provided by the CMHSP/PIHP submitted via the WSA. MDHHS completes the final level of care determination. This determination includes review and approval by MDHHS Medical consultant.

COMMENT: Regarding timely reevaluation of LOC, a reminder notice is currently not sent to the PIHP when reevaluations are due, only when they are overdue. Is this being changed in the WSA?
RESPONSE: Due Dates are available in the WSA, and reports can be run at any time. As a courtesy, MDHHS staff send reminder emails to PIHP leads.

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

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

7. Contact Person(s)

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

Last Name: Coleman

First Name: Jacqueline

Title: Waiver Specialist

Agency: Behavioral and Physical Health and Aging Services Administration, Actuarial Division

Address: P.O. Box 30479

Address 2: 400 S. Pine St, 7th Floor

City: Lansing

State: **Michigan**

Zip: 48909-7979

Phone: (517) 284-1190 **Ext:** ☐ **TTY**

Fax: (517) 335-5007

E-mail: ColemanJ@michigan.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will

continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Meghan Groen

State Medicaid Director or Designee

Submission Date: Jan 13, 2025

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

Last Name: Groen

First Name: Meghan

Title: Senior Deputy Director

Agency: Michigan Department of Health and Human Services, Behavioral and Physical Health and Aging

Address: PO Box 30479

Address 2: 400 S. Pine Street

City: Lansing

State: **Michigan**

Zip: 48933

Phone: (517) 241-7882 **Ext:** ☐ **TTY**

Fax: (517) 335-5007

E-mail: GroenM2@michigan.gov

Attachments

Attachment #1: Transition Plan

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

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

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The requested effective date for removing Enhanced Transportation as a covered waiver service is 10/01/2024. There has been very minimal utilization of this service since the last CWP renewal on 10/01/2019. Our records indicate that CWP beneficiaries are utilizing transportation as a state plan service instead, and not at full capacity. Therefore, Enhanced Transportation does not appear to be providing a benefit to beneficiaries served on the CWP. We do not anticipate a transition plan being necessary to support CWP beneficiaries with this change.

All changes as a result of this waiver renewal will be communicated in writing to the PIHPs and CMHSPs, in addition to being communicated verbally through scheduled waiver renewal webinars, prior to implementation.

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

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Michigan Department of Health and Human Services - Bureau of Physical Health and Aging Services Administration and Bureau of Children's Coordinated Health Policy and Supports

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

a)The Michigan Department of Health and Human Services (MDHHS) is the Single State Medicaid Agency. Oversight of the CWP is provided by the Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. The administration, operation, and oversight of the 1915(c) waivers is shared across two teams: the Bureau of Physical Health and Aging Services Administration (BPHASA) and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS), both which reside in MDHHS. BPHASA and BCCHPS perform the following operational and administrative functions: all administrative functions related to the CWP including review and approval of initial waiver applications submitted by Prepaid Inpatient Health Plans (PIHPs), waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS assurances, including financial accountability. Additionally, BPHASA and BCCHPS staff approve or certify some programs, disseminate information concerning the waiver to potential enrollees and service providers, assist individuals in waiver enrollment, manage waiver enrollment against approved limits, monitor waiver expenditures against approved levels, monitor level of care evaluation activities, conduct site reviews, conduct utilization management functions, determine waiver managed care average costs per unit, conduct training and technical assistance (including providing input for updating the Medicaid Provider Manual) concerning waiver requirements and implementation.

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

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the

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

Appendix A: Waiver Administration and Operation

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The Michigan Department of Health & Human Services (MDHHS) is responsible for assessing the performance of the Prepaid Inpatient Health Plans (PIHPs) in conducting waiver operational and administrative functions. MDHHS monitors PIHPs through the site review process, financial reviews, and waiver enrollment oversight. The review protocols used by the site review team are organized in a way that addresses the functions delegated by MDHHS to the participating PIHPs for the CWP. The delegated functions included in the review protocol are: level of care evaluation; review of beneficiary service plans; prior authorization of waiver services; utilization management; provider qualifications and enrollment; and quality assurance and quality improvement activities. MDHHS manages enrollment against approved limits by reviewing, approving and processing applications and renewal certifications submitted by PIHPs and by processing terminations submitted by PIHPs.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of PIHPs that implement quality assurance/improvement activities as required by contract. Numerator: Number of PIHPs that implement required quality assurance/improvement activities. Denominator: All PIHPs.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):

Other
If 'Other' is selected, specify:
Hearing Decision and Order

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of completed Individual Plans of Service (IPOS) that reflect provider separation of service planning from service delivery. Numerator: Completed IPOS that reflect provider separation of service planning from service delivery. Denominator: All completed IPOS.

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

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

		Proportionate random sample, 95% confidence interval.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of PIHPs who have effective Administrative policies in place regarding HCBS compliance and monitoring processes. Numerator: PIHPs who have administrative policies regarding HCBS compliance and monitoring. Denominator: All PIHPs reviewed.

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

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

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate random sample, 95% confidence interval.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual site reviews to ensure that Michigan's 1915(c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers.

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

Interviews are also conducted with at least one beneficiary whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services.

An additional strategy employed by MDHHS to discover problems is the External Quality Review (EQR). EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. One EQR component addresses PIHP compliance to BBA requirements and is another method of discovery with performance expectations.

b. Methods for Remediation/Fixing Individual Problems

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

The findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Results of the site reviews are also shared with the Quality Improvement Council, which may make recommendations for system improvements at the PIHPs in areas of non-compliance.

On an ongoing basis, customer service functions at the MDHHS and the PIHPs provide assistance to individuals with problems and inquiries regarding services. As part of customer services within MDHHS, the CWP staff also handle multiple beneficiary phone and email inquiries per month and work with the beneficiary and PIHP to address the issues or concerns.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	0	17	☐
	☒	Developmental Disability	0	17	☐
	☒	Intellectual Disability	0	17	☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

The state further specifies its target group(s) as follows:

The following eligibility requirements must be met:

1) The child has a developmental disability OR INTELLECTUAL DISABILITY (as defined in Michigan Mental Health Code).

2) The child must be less than 18 years of age at time of enrollment.

3) The child resides with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.

4) The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

5) The child meets criteria for ICF/IID level of care.

6) The child is at risk of being placed outside of the family home because of the intensity of his/her care needs and the lack of needed supports.

7) The child’s intellectual or functional limitations indicate that he/she is eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

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

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

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

maximum age limit.

Specify:

Michigan believes that transition planning should begin years prior to the beneficiary's 18th birthday. Planning includes an assessment of the beneficiary's current circumstances, resources, service needs, what will be changing and what the beneficiary envisions for his/her future. Beneficiaries who age out of the CWP continue to have mental health service and support needs that require planning on the part of the beneficiary, family and responsible service agencies. It is the purpose of the waiver to provide services to increase the beneficiary's ability to function independently or with supports in a community setting.

As a beneficiary approaches his/her early adult years, the beneficiary, his/her family and the PIHP/CMHSP focus on planning for this period of transition. Many factors are considered during this time: housing, employment, vocational training or school status, emotional/behavioral health, and physical health and safety. During this time it is common to focus on the life domain areas that will impact the beneficiary's success as an adult. The team will focus on enhancing these skills utilizing Medicaid State Plan and waiver services, as well as by helping the beneficiary and family identify and understand what services may be available following disenrollment from the CWP. If the beneficiary's disability impacts his/her ability to earn income, the team will work with the beneficiary to apply for Supplemental Security Insurance (SSI) benefit at age 18. The team will also work with the beneficiary to identify other entitlements that would assist the beneficiary post-CWP.

This is also the time that the team will explore the services and supports the beneficiary needs after his/her 18th birthday and start the transition process with adult services. Whenever possible, adult services staff are encouraged to become part of the CWP planning team to assure a smooth transition to adult services.

Transitions are very different for each individual, but the PIHP/CMHSP assumes the responsibility that the beneficiary's needs are met following disenrollment from the CWP. Beneficiaries who continue to have documented habilitative service needs are given priority to enroll in the Habilitation Supports Waiver (HSW), should the specialized supports and services available under that waiver be appropriate to the beneficiary's needs. This means the beneficiary aging off the CWP does not have to wait for needed services because they are eligible for State Plan services provided by the PIHP, even if there are no HSW slots immediately available. This assures a seamless transition of supports and services that enable the beneficiary to remain in a community setting.

Appendix B: Participant Access and Eligibility

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

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

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

- ( ) **A level higher than 100% of the institutional average.**

  Specify the percentage: [ ]

- ( ) **Other**

  Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	669
Year 2	669
Year 3	669
Year 4	669
Year 5	669

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	669
Year 2	669
Year 3	669
Year 4	669
Year 5	669

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Beneficiaries with Medicaid are not placed on a waiting list for Medicaid State Plan services and the PIHP must provide mental health services and supports appropriate to need. The CWP offers necessary services and supports beyond what is available under the Medicaid State Plan to beneficiaries with developmental disabilities whose needs have placed them at risk for health, safety and/or out-of-home placement. Prior to considering a request for CWP services, the PIHP must review and utilize all available and appropriate Medicaid State Plan services for the beneficiary. If the PIHP determines that a beneficiary remains at risk and meets criteria for ICF/IID, a CWP prescreen is completed and submitted to MDHHS. A request for CWP services begins with a prescreen completed by a Qualified Intellectual Disability Professional (QIDP) and the beneficiary's parent(s) or guardian(s). Determination of severity of need is based on program-specific criteria. Anyone who has expressed an interest in the waiver will be evaluated to determine if they meet minimum eligibility, once that is determined then a prescreen is administered if appropriate. The same policy adhered to across the state. The CWP Priority Weighing Criteria provides a consistent and objective basis on which to determine the priority status of beneficiaries who may be eligible for the program. The QIDP must meet with the beneficiary's family and provide detailed information on CWP service parameters and program requirements. This includes eligibility requirements, available services, access to all qualified providers, opportunities for family participation in planning and active treatment, and financial disclosure requirements. After this discussion, if the family wishes to have their child considered for the CWP, the QIDP completes a prescreen. The prescreen identifies those services to be provided by the CMHSP, based on the beneficiary's identified needs. A parent must sign the completed prescreen and a copy must be maintained in the beneficiary's record. The QIDP then submits the prescreen to MDHHS. Several factors associated with health, safety, well-being and risk of out-of-home placement comprise the CWP Priority Weighing Criteria. When reviewing a prescreen, the BCCHPS-CWP staff determines the score for each of these factors based on the information submitted. The scores for each factor are then totaled. A cover memo and scoring form are completed for each prescreen and available in the WSA to review with the family. If the cover memo contains questions about the prescreen or indicates the availability of other potential resources, the QIDP should follow up and provide updated information to BCCHPS. Re-scoring occurs when updated information is received by MDHHS. If there are subsequent changes in the beneficiary or family's situation that would affect a beneficiary's score based on the Priority Weighing Criteria, the QIDP should submit a brief update describing relevant changes. The PIHP is responsible for updating the prescreen every six months, and submitting a full, current prescreen annually in order for the beneficiary to remain on the Priority Weighing List. The prescreen is not an application, it is an assessment. CMHSP/PIHP send due process if they have determined the child has not met waiver criteria. The MDHHS does not make any eligibility determinations at the time of the prescreen. MDHHS has a prescreen assessment that includes the determination of needs in the areas of self-care, receptive and expressive language, mobility, self-direction, and for children 16 and above the areas of capacity for independent living and economic self-sufficiency are also assessed. The Priority Weighing List contains a sequential list of all prescreen scores. The Priority Weighing List is updated each time prescreens are scored. The prescreen is not an application, it is an assessment. The weighing list invites youth based on level of need. Therefore, the youth with the highest prescreen score is invited to the waiver next. Regardless of if others have been on the list longer. When a CWP opening becomes available, all prescreens that have been received and date stamped at MDHHS are scored before a determination is made as to who will be invited to apply for the CWP opening. The beneficiary whose prescreen is current, and who has the highest score, is invited to proceed with the CWP application process. The QIDP is notified via WSA and asked to contact the family immediately to begin the formal application process. CMHSP/PIHP send due process if they have determined the child has not met waiver criteria. The MDHHS does not make any eligibility determinations at the time of the prescreen.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- (●) **No**
- ( ) **Yes**

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

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

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

  Select one:

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

    Specify percentage:

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

  Specify:

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

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

  Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

Prepaid Inpatient Health Plans (PIHP) complete a CWP assessment to provide a beneficiary with an individual level of care evaluation. PIHP personnel conducting the LOC evaluations and reevaluations are qualified as a Qualified Intellectual Disability Professional (QIDP), as defined in 42 CFR 483.430 and the Michigan Medicaid Provider Manual (MPM). A QIDP is an individual with specialized training in treating or working with a person who has an intellectual disability and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited-licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008.

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

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

The initial evaluation and re-evaluation of the beneficiaries LOC, as submitted by THE PIHP, is reviewed and approved by the MDHHS CWP program staff who are QIDPs or who are obtaining QIDP designation under direct supervision and co-signature of a QIDP.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify

the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Children evaluated for the Children's Waiver Program (CWP) must meet the admission criteria for an ICF/IDD as specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. and as identified in the Michigan Medicaid Provider Manual (MPM). Section 3.13 of the MPM states: "Beneficiaries must meet ICF/IDD level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a Qualified Intellectual Disability Professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications." The criteria are outlined below. The child must meet all criteria outlined below: 1. I/DD Diagnosis: Have an intellectual or developmental disability or a related condition that started before age 22 and continues indefinitely. Be aware, associated conditions are functionally defined by how they affect the person, not by specific diagnoses. 2. In Need of Active Habilitative Treatment: Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status. Additionally, the child is in need of a 24-hour plan of care. Assess whether the person has a substantial functional limitation beyond their life stage/age* to: A. Complete or participate in Activities of Daily Living B. Understanding and use of language and learning at age-appropriate levels. C. Mobility D. Self-direction E. Over the age of 16 – Economic self-sufficiency and capacity for independent living F. Medical G. Behavioral 3. Risk of out of home placement: Parent Stress and risk of out of home placement determination*: (*parent stress or physical/mental documented challenges may indicate the fact that the child or family is at risk. Below are examples and not an exhaustive list. Italics are tips for prescreen.) A. Child requires eyes on supervision 24 hours per day due to current level of functioning (no natural supports) B. Parental burn out, stressed, tired, overwhelmed. (considering placing their child out of the family home). C. Parent doesn’t get sleep due to child’s sleep disturbance challenges - must include examples in prescreen. D. Parental work/job has been negatively impacted in some way. E. Child has police contact or trips to ED due to behaviors within last 6 months. (Dates must be provided) F. Child/Family has received medical treatment due to injuries caused by behaviors. (Dates must be provided) G. Multiple children in the home either under the age of 5, or also with mental health challenges. MDHHS will begin utilizing an assessment (i.e. the Michigan Child and Adolescent Needs and Strengths (MichiCANS)) for all beneficiaries with I/DD to identify those who may meet ICF LOC criteria to assist the PIHP to identify potential enrollees onto the CWP. The use of this new I/DD assessment will improve the identification of beneficiaries who may have a need for CWP services prior to the formal enrollment process. In addition to the I/DD assessment, most often a psychosocial assessment is completed. The method for determining LOC is as follows: The QIDP reviews any relevant supporting documentation regarding the child’s functional skills (e.g., clinical assessments, individual educational plans from the child’s school, medical reports) to determine whether the child meets ICF/IDD level of care criteria as delineated in 42 CFR 483.440. The process / method used to evaluate LOC for the waiver is the same as used to evaluate institutional LOC. The State ensures consistency in the LOC determination in four ways. First, at the level of the PIHP, individual LOC determinations/re-evaluations are reviewed by the QIDP's supervisor or by another administrator designated by the PHIP. This review is evidenced by the designee's signature on the waiver certification form. Second, consistency across PIHPs is monitored and assured by the site review process, which reviews relevant supporting documentation regarding the child’s functional skills (e.g., clinical assessments, individual educational plans from the child’s school, medical reports) to confirm the ICF/IDD LOC determination made by the PIHP. Third, MDHHS staff provide on-going technical assistance, training and consultation on LOC determination and documentation. Fourth, LOC determinations are reviewed MDHHS CWP staff who is a QIDP.

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

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

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain

how the outcome of the determination is reliable, valid, and fully comparable.

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

The process/method used for reevaluating level of care for waiver beneficiaries is the same as the process/method for evaluation of the beneficiary's initial level of care determination.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

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

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

Specify the qualifications:

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of enrolled waiver consumers that are reevaluated within 365 days of their initial level of care (LOC) evaluation or their last annual LOC reevaluation. Numerator: Number of enrolled consumers who LOCs were reevaluated within 365 days of their last LOC evaluation. Denominator: All enrolled consumers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial LOC evaluations where the LOC criteria was accurately applied. Numerator: Number of initial LOC evaluations where the LOC criteria was accurately applied. Denominator: All LOC evaluations.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of LOC re-evaluations where the LOC criteria was accurately applied. Numerator: Number of LOC re-evaluations where the LOC criteria was accurately applied. Denominator: All LOC re-evaluations.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

During the site review process, CWP program staff review all documentation to assure the QIDP used the prescribed processes and correctly documented Level of Care (LOC) determinations.

Regarding timely reevaluation of LOC: The PIHP and the CWP track due dates for each beneficiary's LOC reevaluation. Due dates are available in the WSA and reminder notices are sent to the designated staff at the PIHP when reevaluations are due. When MDHHS does not receive a timely waiver recertification from the PIHP, a reminder email is sent to the PIHP requesting the documentation.

If, in the course of MDHHS-CWP staff review of documentation for any purpose (e.g. review of beneficiaries with the highest needs, initial or annual recertification) a question about LOC arises, an email is sent by CWP staff to identify questions or issues that must be addressed by the PIHP. The response is reviewed by the MDHHS staff person who sent the email to determine that appropriate action was taken and if any additional follow-up is necessary, such as request for additional information. Responses to emails are expected within 1-2 business days.

b. Methods for Remediation/Fixing Individual Problems

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

MDHHS-CWP staff send emails to the PIHP to identify questions or issues that must be addressed regarding individual LOC determinations. The response is reviewed by the CWP staff to determine that appropriate action was taken and if any additional follow-up is necessary, such as request for additional information. Responses to emails are expected within 1-2 business days.

During the site review process, a sample of clinical records is reviewed, including all assessments and documentation that underpin the waiver certification level of care determination. Potential problems with level of care evaluation/reevaluation may be identified during these annual site reviews, and are documented by MDHHS staff using the Site Review Protocol. The findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Regarding timely reevaluation of LOC: If, despite reminder notices, the MDHHS does not receive a timely waiver recertification, another email is sent to the case manager and his/her supervisor requesting information as to why the recertification has not been completed. If it is the agency that is responsible for the delay, the agency is informed they must provide the certification to MDHHS within 10 working days of the call. If the delay is due to the family not following through with the recertification process, the PIHP is required to inform the family that because the recertification is past due, the beneficiary's eligibility for the CWP is at risk and the recertification must be completed within 10 working days to maintain eligibility. If the family subsequently does not cooperate with the recertification, the PIHP will issue a termination notice to the family, including their right to a Medicaid Fair Hearing. The PIHP must continue to provide services until one of three things occurs: 1) the family files a Request for Fair Hearing within 12 days of issuance of the letter and a Decision and Order is issued upholding the Department, 2) the legal representative indicates in writing they wish to withdraw the beneficiary from the waiver, or 3) the recertification is received within 10 working days.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

When a beneficiary is invited to apply for the CWP (pursuant to the process described in B-3-f), the QIDP contacts the family to begin the formal application process. One of the first steps in this process includes meeting with the family to explain the process and timelines related to the waiver application, options and choices afforded the beneficiary/family, and rights and responsibilities associated with eligibility for the waiver. While the PIHP's QIDP is responsible for assuring and documenting several aspects of the application process (e.g., securing necessary signatures on the Waiver Certification Form), the beneficiary's parent/guardian representative is encouraged to invite others to participate as a natural support or as a facilitator.

An essential feature of the application process includes discussion with the family (and provision of information) about services and supports available under the waiver, and the family's right to choose among an array of qualified providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements for each service/support needed by the beneficiary. The purpose of these discussions and information-sharing is to enable the family to make an informed decision about choosing home and community-based waiver services as an alternative to institutional care.

Section 3 of the Waiver Certification form is used to document that the parent/guardian was informed of their right to choose between community-based services provided by the CWP and ICF/IID placement/services. The parent/ guardian receives a copy of the signed Waver Certification Form. Section 3 also documents that the parent/guardian was informed of their right to choose among qualified service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangement.

The Waiver Certification form is maintained in the beneficiary's clinical record at the PIHP, and in the child's MDHHS case file. All aspects of choice are discussed with the beneficiary's family at the time of initial certification for the waiver. Choices (relative to home and community-based services over institutional services and to direct service providers) typically are discussed each time the beneficiary's plan of care is reviewed (which may be as frequent as monthly). MDHHS CWP staff confirms completion of Section 3 of the Waiver Certification Form at the time of initial certification for the CWP and at the time of annual recertification for the CWP. During PIHP site reviews, the site review team reviews the PIHP's policy/procedures related to offering/assuring informed choice of qualified providers as describe above and of waiver services in lieu of institutional services.

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

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

Appendix B: Participant Access and Eligibility

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

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

The contract between MDHHS and PIHPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. Each PIHP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHPs access system.

Access system services must be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. The PIHP must arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by telephone access for hearing impaired individuals. Telephone lines must be toll-free and accommodate people with Limited English Proficiency (LEP) and other linguistic needs, as well as be accessible for individuals with hearing impairments and must accommodate persons with diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.

MDHHS's contract with PIHPs requires that PIHPs comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency, 45 CFR 92.201 and Section 1557 of the Patient Protection and Affordable Care Act. PIHPs are expected to take reasonable steps to provide meaningful access to each individual beneficiary with limited English Proficiency, such as language assistance services, including but not limited to, oral and written translation. To take into consideration the special needs of beneficiaries with disabilities or LEP, PIHPs must ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids, such as and Teletypewriter/Text Telephone (TTY/TDY) and American Sign Language (ASL), and services are available upon request at no cost, and how to access those services as referenced in 42 CFR Parts 438.10(d)(3) and 438.10(d)(4).

All materials must be written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 6.9 grade level criteria). All materials must be in an easily understood language and format and use a font size no smaller than 12 point. All informative materials, including the provider directory, must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on their website, in a machine-readable file and format. Requirements for the information to be made available in the language appropriate to the specific individual to aid them to access and use services in accordance with 42 CFR 435.905(b) will be followed. Such materials must be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2000, Federal Register Vol. 65, August 16, 2000). All such materials must be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries must be informed of how to access the alternative formats.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Respite**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Community Living Supports**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Care Training, Family**		
Other Service	**Home Care Training, Non-Family**		
Other Service	**Overnight Health and Safety Support**		
Other Service	**Specialized Medical Equipment & Supplies**		
Other Service	**Therapeutic Activities**		
Other Service	**Vehicle Modifications**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Respite care can be provided in the following locations: the beneficiary's home or place of residence; home of a relative or family friend's home in the community; Licensed Foster Family Home; Licensed Foster Family Group Home; Licensed Children's Camp; Licensed Children's Therapeutic Group Home.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

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

Families may use up to 1,152 hours of respite service per fiscal year, in accordance with the consumer's IPOS. The billable procedure code for respite is a 15-minute unit, which equates to a maximum respite benefit of 4,608 units per fiscal year.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide-level provider
Agency	PIHP or contracted provider
Agency	Licensed Children's Camp; Licensed Family Foster Home; Licensed Foster Family Group Home; Licensed Children's Therapeutic Group Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Aide-level provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

NA

Other Standard *(specify):*

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP/CMHSP to provide the service.

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Children's Camp; Licensed Family Foster Home; Licensed Foster Family Group Home; Licensed Children's Therapeutic Group Home

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Division of Child Welfare Licensing is the regulatory authority. MDHHS also verifies provider qualifications during regular and special investigation visits.

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications.

Frequency of Verification:

Licenses are issued/renewed for a two-year period. Providers of respite services are verified for meeting qualifications prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

Financial Management Services (FMS) is an independent legal entity that acts as the fiscal agent for the purpose of assuring financial accountability for the funds authorized to purchase the services and supports identified in the beneficiary's plan of service. The FMS provider receives the funds; makes payments authorized by the beneficiary's representative to providers of services and supports; and acts as an employer agent when the beneficiary's representative directly employs staff or other service providers.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications stated below
Agency	Financial Management Services Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Management Services Agency

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

CLS provides assistance to the family in the care of their child while facilitating the beneficiary's independence and integration into the community. The supports, as identified in the IPOS, are provided in the beneficiary's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living (such as personal hygiene, household chores, and socialization) may be included. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary enabling them to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Community Living Supports includes:
-Assistance with skill development related to:
-Activities of daily living (such as personal hygiene);
-Household chores;
-Socialization;
-Improving communication and relationship-building skills; and
-Participation in leisure and community activities.
-Staff assistance, support and/or training with such activities as:
-Improving the beneficiary's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors;
-Non-medical care (i.e., not requiring nurse or physician intervention);
-Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence;
-Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.);
-Assisting the family in relating to and caring for their child;
-Attendance at medical appointments;
-Acquiring OR PROCURING products, resources and accommodations other than those listed under shopping AND NON-MEDICAL SERVICES
-Reminding, observing, rewarding and monitoring of pro-social behaviors.
-Medication administration.
-Staff assistance with preserving the health and safety of the beneficiary in order that he may reside or be supported in the most integrated, independent community setting.

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP or contracted provider
Individual	Aide-level provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Individual

Provider Type:

Aide-level provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

NA

Other Standard *(specify):*

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. 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)

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Licensed Builder or Contractor

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to initiation of services.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

PIHP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Care Training, Family

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Federal Financial Participation (FFP) is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan. FFP is not available for the costs of travel, meals, and overnight lodging to attend a training event or conference

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Care Training, Non-Family

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QIDP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Overnight Health and Safety Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other

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

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

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

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

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

Service Definition *(Scope):*

Overnight Health and Safety Support is defined as the need for someone to be present to prevent, oversee, manage, direct, or respond to a beneficiary's disruptive, risky, or harmful behaviors, during the overnight hours. Overnight Health and Safety Support is indicated for a person who is non-self-directing, confused, has a cognitive impairment or whose physical functioning is such that they are unable to respond appropriately in an emergency. It is further indicated for beneficiaries who have inconsistency in, or an inability to, regulate sleep patterns. For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period. The need for Overnight Health and Safety Support must be reviewed and established through the person-centered planning process with the specific reasons for this service and what support activities will be provided.

Overnight Health and Safety Support may be appropriate when:
-Service is necessary to safeguard against injury, hazard, or accident, including monitoring for non-life-threatening self-harm behaviors that require redirection.
-Service will allow beneficiary to remain at home safely after all other available preventive interventions have been undertaken, and the risk of injury, hazard or accident remains
-Assistance is needed with instrumental activities of daily living (IADLs) that cannot be pre-planned or scheduled
-The need is caused by a medical condition or the form of supervision required is medical in nature (i.e., wound care, sleep apnea, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.)

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

The following exceptions apply for Overnight Health and Safety Support:
-Payments for Overnight Health and Safety Support may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.
-The Overnight Health and Safety Support service cannot be provided in a licensed residential setting.
-If the beneficiary receiving Overnight Health and Safety Support demonstrates the need for CLS or Respite, the IPOS must document coordination of services to assure no duplication of services provision with Overnight Health and Safety Support.

It does not include friendly visiting or other social activities.
It is not available for medical needs beyond provider qualification requirements (aide level staff) for this service.
Is not available in anticipation of a medical emergency.
Is not available to prevent or control severely anti-social or aggressive recipient behavior.
Is not available for a person without a physical, cognitive, or memory impairment who has anxiety about being alone at night.
Is not an alternative to inpatient psychiatric treatment and is not available to prevent potential suicide or other life-threatening self-harm behaviors.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide-level provider
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Aide-level provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three years thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Aides must meet criteria specified in the Michigan Medicaid Provider Manual. Aides must be:
At least 18 years of age;
Able to prevent transmission of communicable disease/to practice universal precaution and infection control techniques;
Able to perform basic first aid procedures;
Trained in the consumer's individual plan of service (IPOS);
Trained in recipient rights;
Able to communicate expressively and receptively in order to follow the individual plan of service (IPOS) requirements and beneficiary-specific emergency procedures, and to report on activities performed;
In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien).

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment & Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment & Supplies

Provider Category:

Agency

Provider Type:

PIHP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Therapeutic Activities

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

This waiver service does not replace those services available under the state plan. All medically necessary therapeutic services for children under age 21 are covered in the state plan benefit pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

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

Services are limited to four sessions per therapy per month.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist, Equine Therapist
Agency	PIHP or contracted provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Activities

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

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

An equine therapist must hold a current license in the State of Michigan as an occupational therapist, physical therapist, speech pathologist, clinical social worker, psychologist, or professional counselor. The equine therapist must have appropriate specialized training and experience and must deliver services within their scope of practice. Specialized training includes (but is not limited to) the following credentials:

- Certification by the American Hippotherapy Certification Board
- Certification by other MDHHS-approved certification boards
- Completion of documented coursework in an applicable training program that is administered by an accredited university and approved by MDHHS

Certificate *(specify):*

Therapeutic Recreation Specialist, Music Therapist, and Art Therapist are not required to be board certified to provide services in their field, but must have completed all educational coursework requirements and be under the appropriate supervision working toward board certification in their respective fields (Therapeutic Recreation Specialist: National Council for Therapeutic Recreation (NCTRC); Music Therapist: National Music Therapy Registry (NMTR); Art Therapist: Art Therapy Credentials Board (ATCB)).

Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB).

Other Standard *(specify):*

Service providers must meet PIHP/CMHSP provider qualifications, including appropriate licensure/certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Activities

Provider Category:

Agency

Provider Type:

PIHP or contracted provider

Provider Qualifications

License *(specify):*

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

An equine therapist must hold a current license in the State of Michigan as an occupational therapist, physical therapist, speech pathologist, clinical social worker, psychologist, or professional counselor. The equine therapist must have appropriate specialized training and experience and must deliver services within their scope of practice. Specialized training includes (but is not limited to) the following credentials:

- Certification by the American Hippotherapy Certification Board
- Certification by other MDHHS-approved certification boards
- Completion of documented coursework in an applicable training program that is administered by an accredited university and approved by MDHHS

Certificate *(specify):*

NA

Other Standard *(specify):*

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Therapeutic Recreation Specialist, Music Therapist, Art Therapist, and Equine Therapist are not required to be board certified to provide services, but must have completed all educational coursework requirements and be under the appropriate supervision working toward board certification or appropriate State of Michigan licensure in their respective fields.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP or contracted agency verifies provider qualifications. When a contracted agency is the direct provider of services, the agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Chart and Provider Qualifications. If the provider is hired directly by a beneficiary through a Choice Voucher arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

The following are specifically excluded:
1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	PIHP

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

PIHP

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The agency must be certified by MDHHS as a PIHP/CMHSP or the agency must be contracted by the PIHP to provide the service.

Frequency of Verification:

Prior to the delivery of services and every three years thereafter.

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

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

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

The PIHPs or their contracting agency are responsible for conducting case management functions and for the coordination of waiver services on behalf of waiver beneficiaries. Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP).

Appendix C: Participant Services

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

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

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

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

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

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

(b) The PIHP/CMHSP or its contracted provider agency is responsible for conducting a search that reveals information substantially similar to information found on 1) an Internet Criminal History Access Tool (ICHAT) check, 2) a national and state sex offender registry check, or 3) Office of Inspector General (OIG) checks.

(c) The Michigan Medicaid Provider Manual and the Michigan Mental Health Code state that staff must be in good standing with the law. The definition of "be in good standing with the law" means the person is not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, or not an illegal alien. Criminal history/background investigations must be saved in the employee's personnel file. The annual site review process is the mechanism for ensuring that mandatory background checks have been completed.

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

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

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

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

The state maintains an abuse registry for children only which tracks Children's Protective Services (CPS) cases that result in confirmed methamphetamine production, confirmed serious abuse or neglect, confirmed sexual abuse, or confirmed sexual exploitation will be classified as a central registry case in Michigan. In addition, select criminal convictions involving children will result in placement on central registry. At this time there is no adult registry screening that the state maintains

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

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

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

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

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

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

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

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom

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

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

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

◉ **Other policy.**

Specify:

Michigan does not allow payments to legal guardians or to relatives who are legally responsible for providing services to the beneficiary. Subject to this qualification relatives may be paid if they meet all provider qualifications. Services provided by relatives meeting these criteria are subject to the same claim processing edits (including quantity parameters) as services provided by non-relatives. Whenever a legally responsible individual or relative/legal guardian is paid for the provision of a waiver service, the person must meet the provider qualifications that apply to a service and there must be a properly executed provider agreement. In addition, other requirements such as the proper documentation and monitoring of the provision of services also apply. The number of hours a relative may be authorized to provide would be the same level as hired staff. A relative that would not otherwise provide service without payment can provide CLS or respite. Michigan does not pay guardians to provide services.

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

Any entity that meets certification requirements as specified in Section 232a of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto, can be certified by MDHHS as a Community Mental Health Service Program (CMHSP), and can enroll with Medicaid as a PIHP/CMHSP. Waiver contract language requires Michigan's PIHPs/CMHSPs to assure sufficient service capacity to meet the needs of CWP recipients. In addition, PIHPs/CMHSPs routinely expand their provider panel to meet the needs of CWP consumers and upon request of consumers to add direct service providers. The PIHP is the Provider of services. Individuals are given a choice of direct service providers that contract with the PIHP/CMHSP. If the family identifies a qualified provider, they refer that provider to the PIHP/CMHSP to become affiliated with the PIHP/CMHSP. Qualified providers chosen by the beneficiary should be placed on the provider panel.

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

At time of enrollment in the CWP case managers inform parents/legal guardians of their right to choose among the various waiver services and their right to choose among subcontracted providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual site reviews to ensure that Michigan's 1915(c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

b. Methods for Remediation/Fixing Individual Problems

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

the methods used by the state to document these items.

The findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

Results of the site reviews are also shared with the Quality Improvement Council, which may make recommendations for system improvements at the PIHPs in areas of non-compliance.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

FOR HOME AND COMMUNITY BASED (HCB) SETTING COMPLIANCE, RESIDENTIAL SETTINGS INCLUDED THOSE THAT ARE PROVIDER OWNED AND OPERATED SETTINGS AND NON-RESIDENTIAL SETTINGS. THESE SETTINGS HAVE COMPLETED A RIGOROUS REVIEW AND REMEDIATION/VALIDATION PROCESS CONSISTING OF A SURVEY AND SITE REVIEW TO ENSURE THAT THESE SETTINGS MEET THE HOME AND COMMUNITY-BASED SERVICES (HCBS) SETTINGS RULE. THROUGH THE SURVEY AND SITE REVIEW PROCESS, ANY SETTING DEEMED NON-COMPLIANT WITH THE HCBS RULE WAS REMEDIATED AND REVIEWED TO CONFIRM COMPLIANCE BY MARCH 17, 2023, ANY SETTING THAT WAS FOUND COMPLIANT WAS VALIDATED TO ENSURE ACCURACY. IN ADDITION, MDHHS REQUIRED THAT ANY NEWLY CONTRACTED SETTING PRIOR TO THE MARCH 17, 2023, DATE, MUST BE FULLY COMPLIANT WITH THE HCBS RULE PRIOR TO CONTRACTING WITH THE PIHP. THIS IS ACCOMPLISHED THROUGH THE PROVISIONAL APPROVAL PROCESS THAT REQUIRES THE PIHP TO CONDUCT A THOROUGH REVIEW TO ENSURE THE SETTING IS FULLY COMPLIANT PRIOR TO THE SETTINGS APPROVAL TO PROVIDE MEDICAID FUNDED HCBS SERVICES. THIS REVIEW INCLUDES AN ONSITE ASSESSMENT WHICH INCLUDES A PHYSICAL INSPECTION OF THE SETTING, DOCUMENTATION REVIEW OF THE INDIVIDUAL PLAN OF SERVICE (IPOS), TREATMENT PLANS, POLICIES AND PROCEDURES AND STAFF INTERVIEWS TO ENSURE COMPLIANCE WITH MDHHS HCBS REQUIREMENTS.

IF A SETTING IS NOT FULLY COMPLIANT THE PIHP WILL WORK WITH THE SETTING TO ENSURE REMEDIATION IS CONDUCTED AND WILL MONITOR THE SETTING ON AN ONGOING BASIS TO ENSURE CONTINUED COMPLIANCE.

ONGOING MONITORING AND COMPLIANCE INCLUDES THE FOLLOWING PROCESSES IMPLEMENTED BY MDHHS TO ENSURE COMPLIANCE WITH THE HCBS RULE:
-THE PIHPS ARE CONTRACTUALLY OBLIGATED TO ENSURE THEIR HCBS PROVIDER NETWORK IS COMPLIANT WITH THE RULE. INITIALLY, AND AT THE TIME OF CONTRACT RENEWAL EACH SETTING MUST BE FOUND FULLY COMPLIANT WITH THE HCBS RULE AND THE PIHPS MUST COMPLETE THE FOLLOWING MONITORING PROCESSES:

-ANNUAL PHYSICAL ASSESSMENTS (IN-PERSON PHYSICAL INSPECTION) OF EACH SETTING AND -TRIENNIAL COMPREHENSIVE ASSESSMENTS (DOCUMENTATION REVIEW OF BENEFICIARY RECORDS AND SETTING POLICIES AND PROCEDURES) FOR EACH WAIVER PARTICIPANT.
-MDHHS WILL UTILIZE ITS SITE REVIEW PROCESS TO ENSURE COMPLIANCE.
-ADDITIONAL PERFORMANCE MEASURES HAVE BEEN INSTITUTED THE IN THE CURRENT WAIVER APPLICATION TO BE REVIEWED ANNUALLY TO MONITOR SETTING COMPLIANCE.
-ANY AREAS OF NONCOMPLIANCE WILL REQUIRE REMEDIATION, WITHIN MDHHS ESTABLISHED TIME FRAME.
-THE PIHPS WILL REPORT ON ASSESSMENT PROGRESS AND COMPLIANCE STATUS ON A QUARTERLY BASIS ON A TRIENNIAL CYCLE FOR EACH WAIVER PARTICIPANT SERVED WITHIN THE REGION.
-THE PIHPS AND THEIR AFFILIATED CMHSPS OR CONTRACTED PROVIDERS MUST HAVE EFFECTIVE ADMINISTRATIVE POLICIES REGARDING THE HCBS COMPLIANCE AND MONITORING PROCESS.

After conducting an initial review of settings under the Children’s Waiver Program, MDHHS determined that settings under this waiver should be presumed to be compliant with the rule. All children under this waiver program are served in family homes, which have presumed compliance under the rule. PRIVATE HOMES THAT ARE PRESUMED COMPLIANT WILL BE INCLUDED IN THE STATE’S ONGOING MONITORING PROCESS.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Plan of Service (IPOS)

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

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

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

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

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

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

☐ **Social Worker**
Specify qualifications:

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

A Qualified Intellectual Disabilities Professional (QIDP) is an individual with specialized training in treating or working with a person who has an intellectual disability and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited-licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008.

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

The PIHPs have responsibility utilization management and for development and monitoring person-centered service plans and the network's implementation of the CWP services, which require additional conflict of interest protections including separation of service planning and service delivery to align with the MDHHS approved CFA&P scenarios, as outlined in MDHHS CFA&P requirements and PIHP contracts.

In rural and or tribal communities and as outlined in MDHHS' Conflict Free Access and Planning "only-willing and qualified provider designation" process and approved by CMS, the State may approve an entity to provide both service planning and direct waiver services to the same beneficiary. In those limited circumstances and as defined in MDHHS' "only-willing and qualified provider designation" process the entity must implement protections to mitigate conflict of interest.

IF THE BENEFICIARY CHOOSES TO NOT HAVE A SUPPORTS COORDINATOR, THERE ARE A NUMBER OF ALTERNATIVES AVAILABLE FOR ASSISTING THE BENEFICIARY WITH THE DEVELOPMENT OF THE IPOS. THE BENEFICIARY COULD ALSO CHOOSE A SUPPORTS COORDINATOR ASSISTANT OR AN INDEPENDENT SERVICE AND SUPPORTS BROKER TO HELP WITH DEVELOPING THE IPOS.

THE PIHPS DELEGATE THE RESPONSIBILITIES OF PLAN DEVELOPMENT AND MONITORING TO CMHSP, OR CONTRACTED PROVIDER CHOSEN BY THE INDIVIDUAL OR FAMILY. MICHIGAN'S PROVIDERS, INCLUDING CMHSPS IN THEIR ROLE AS PROVIDER, MAY NOT OFFER BOTH SERVICE PLANNING AND DIRECT SERVICES TO THE SAME BENEFICIARY WITHOUT AN ONLY WILLING AND QUALIFIED PROVIDER DESIGNATION. SEE SECTION D.1.B FOR MORE INFORMATION ABOUT CONFLICTS OF INTEREST.

QUALIFICATIONS:

SUPPORTS COORDINATOR ASSISTANTS AND INDEPENDENT SERVICES AND SUPPORTS BROKERS: MINIMUM OF A HIGH SCHOOL DIPLOMA AND EQUIVALENT EXPERIENCE (I.E., POSSESSES KNOWLEDGE, SKILLS AND ABILITIES SIMILAR TO SUPPORTS COORDINATOR QUALIFICATIONS) AND FUNCTIONS UNDER THE SUPERVISION OF A QUALIFIED SUPPORTS COORDINATOR. INDEPENDENT SERVICES AND SUPPORTS BROKERS MUST MEET THESE QUALIFICATIONS AND FUNCTION UNDER THE GUIDANCE AND OVERSIGHT OF A QUALIFIED SUPPORTS COORDINATOR OR CASE MANAGER.

IF THE BENEFICIARY WANTS ANOTHER PROVIDER INSTEAD OF A SUPPORTS COORDINATOR OR SUPPORTS COORDINATOR ASSISTANT OR INDEPENDENT SUPPORTS BROKER, THE PIHP WILL ASSIST THE BENEFICIARY TO IDENTIFY A PROVIDER WITHIN THE NETWORK (OR ENROLL A QUALIFIED PROVIDER UPON REQUEST IF POSSIBLE) WHO POSSESSES EQUAL QUALIFICATIONS TO A SUPPORTS COORDINATOR

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

THE STATE HAS CHOSEN TO LEVERAGE THE OPTION OF ALLOWING FOR ONLY WILLING AND QUALIFIED ENTITIES TO PROVIDE DIRECT SERVICES AND PERFORM ASSESSMENT AND PLANS OF CARE IN A GEOGRAPHICAL AREA.

WHEN PROVIDERS OF DIRECT SERVICE ARE GIVEN RESPONSIBILITY TO PERFORM ASSESSMENTS AND PLANS OF CARE, THEY MUST BE THE ONLY WILLING AND QUALIFIED ENTITY IN A GEOGRAPHICAL AREA.

THE ONLY WILLING AND QUALIFIED PROVIDER DESIGNATIONS ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:

1A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA

1B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TOINDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES TRIBAL PROVIDERS)

2: PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS

3: PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES “LACK OF OTHER DIRECT SERVICE PROVIDERS”)

THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED.

CONFLICT OF INTEREST PROTECTIONS: MDHHS IS RESPONSIBLE FOR IDENTIFYING QUALIFIED PROVIDERS TO RECEIVE A OWQP DESIGNATION USING CLEAR AND PUBLISHED SET OF CRITERIA. MDHHS FACILITATES THE OWQP DESIGNATION PROCESS EVERY THREE YEARS.

MDHHS DEFINES THE CRITERIA FOR OWQP DESIGNEES, COMPLIANCE EXPECTATIONS AND REQUIREMENTS, INCLUDING ACCEPTABLE SAFEGUARDS TO LIMIT CONFLICTS OF INTEREST.

MDHHS WILL DIRECTLY OVERSEE AND MONITOR OWQP DESIGNATIONS THROUGH STATE POLICY, MEDICAID PROVIDER MANUAL LANGUAGE, CONTRACT LANGUAGE, SITE REVIEWS, AUDITS, AND DATA ANALYSIS.

MDHHS MONITORING WILL INCLUDE ONGOING EFFORTS TO EXPAND THE PROVIDER NETWORK TO MAXIMIZE CHOICE FOR BENEFICIARIES.

MDHHS CONDUCTS RETROSPECTIVE REVIEWS OF OWQP DESIGNATION APPLICATIONS FOR COMPLIANCE.

1. ONLY-WILLING-AND-QUALIFIED PROVIDER (OWQP): PROVIDERS WITH MDHHS-APPROVED OWQP DESIGNATION MUST ESTABLISH AND ATTEST TO TO PROTECT AGAINST CONFLICTS OF INTERESTS. SAFEGUARDS REQUIRED FOR MDHHS-APPROVED OWQP DESIGNEES MUST INCLUDE, AT MINIMUM:

A. AN OPPORTUNITY FOR THE PARTICIPANT TO DISPUTE THE STATE’S ASSERTION THAT THE CASE MANAGEMENT ENTITY IS THE ONLY WILLING AND QUALIFIED PROVIDER THROUGH AN ALTERNATIVE DISPUTE RESOLUTION PROCESS;

B. ANNUAL EVALUATION BY A STATE AGENCY (MDHHS/BPHASA);

C. ADMINISTRATIVELY SEPARATE THE PLAN DEVELOPMENT FUNCTION FROM THE DIRECT

SERVICE PROVIDER FUNCTIONS (INCLUDING OVERSIGHT BY SEPARATE SUPERVISORS);

D. REQUIRE THE INDIVIDUAL CONDUCTING SERVICE PLANNING OR ELIGIBILITY/NEEDS ASSESSMENT IS NOT THE SAME INDIVIDUAL PROVIDING DIRECT SERVICE.

2. OVERALL STRUCTURE: MICHIGAN'S PROVIDERS, INCLUDING CMHSPS IN THEIR ROLE AS PROVIDER, MAY NOT OFFER BOTH SERVICE PLANNING AND DIRECT SERVICES TO THE SAME BENEFICIARY WITHOUT AN OWQP DESIGNATION. TO BE COMPLIANT WITH CONFLICT FREE ACCESS AND PLANNING (CFA&P) REQUIREMENTS, CMHSPS MUST ARRANGE THEMSELVES IN ONE OF TWO SCENARIOS OR RECEIVE AN OWQP DESIGNATION AS THE THIRD SCENARIO.

A. SCENARIO 1: THE CMHSP CONTRACTS OUT BOTH SERVICE PLANNING AND DIRECT SERVICE FUNCTIONS TO PROVIDERS. THE CMHSP MUST ENSURE THAT A MEMBER IS REFERRED TO PROVIDER A FOR SERVICE PLANNING AND A SEPARATE PROVIDER B FOR DIRECT SERVICES.

B. SCENARIO 2: THE CMHSP DIRECTLY OFFERS BOTH SERVICE PLANNING AND DIRECT SERVICES AND CONTRACTS WITH PROVIDERS FOR THESE FUNCTIONS. THE CMHSP MAY CONTINUE TO PROVIDE SERVICE PLANNING OR DIRECT SERVICES TO A SINGLE MEMBER BUT MUST ENSURE A MEMBER IS REFERRED TO A SEPARATE PROVIDER A TO CONDUCT THE REMAINING FUNCTION.

C. SCENARIO 3: SEE INFORMATION ABOVE ON OWQP DESIGNATION.

3. THE PIHPS DELEGATE THE RESPONSIBILITIES OF PLAN DEVELOPMENT AND MONITORING TO CMHSP, OR CONTRACTED PROVIDER CHOSEN BY THE INDIVIDUAL OR FAMILY.

4. OVERALL SAFEGUARDS: MDHHS REQUIRES SAFEGUARDS AT SEVERAL LAYERS TO PROTECT AGAINST CONFLICTS OF INTEREST. SAFEGUARDS ARE IMPLEMENTED TO DEFINE, IDENTIFY, MITIGATE, AND MONITOR POTENTIAL OR ACTUAL CONFLICTS OF INTEREST.

A. MDHHS OVERSEES THE DEVELOPMENT OF IMPLEMENTATION PLANS TO ACCOMPLISH THE MDHHS ESTABLISHED SAFEGUARDS.

B. THE FOLLOWING SAFEGUARDS ARE IDENTIFIED IN CONTRACTS.

I. MDHHS CONTRACTS WITH PIHPS RESTRICTS THE ENTITY (I.E., CMHSP OR CONTRACTED PROVIDER) THAT DEVELOPS THE PERSON-CENTERED SERVICE PLAN FROM PROVIDING SERVICES WITHOUT THE DIRECT APPROVAL OF THE STATE.

II. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO MAINTAIN AND PUBLISH A COMPLETE PROVIDER DIRECTORY, INCLUDING INDEPENDENT FACILITATORS, IN HARD COPY AND WEB-BASED FOR-MATS. INFORMATION MUST BE UPDATED ON AN ONGOING BASIS TO MAINTAIN ACCURACY.

III. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO BE RESPONSIBLE FOR UTILIZATION MANAGEMENT OF SERVICES COVERED UNDER THE SCOPE OF CFA&P IMPLEMENTATION. THE PIHP CANNOT DELEGATE THEIR AUTHORIZATION AND UTILIZATION MANAGEMENT RESPONSIBILITIES TO OTHER ENTITIES.

IV. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO PROVIDE FULL DISCLOSURE TO BENEFICIARIES AND ASSURANCE THAT BENEFICIARIES ARE SUPPORTED IN EXERCISING THEIR RIGHT TO FREE CHOICE OF PROVIDERS AND ARE PROVIDED INFORMATION ABOUT THE FULL RANGE OF WAIVER SERVICES, NOT JUST THE SERVICES FURNISHED BY THE ENTITY THAT IS RESPONSIBLE FOR THE SERVICE PLAN DEVELOPMENT.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Michigan uses a Person-Centered Planning (PCP) process mandated by law. “PCP means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities” MCL 330.1700(g). The PCP planning process: 1) focuses on the individual’s life goals, interests, desires, preferences, strengths and abilities as the foundation for planning process; 2) identifies outcomes based on the individual’s life goals, interests, desires and preferences; 3) makes plans for the individual to work toward and achieve identified outcomes; 4) determines the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system; and 5) develops an Individual Plan of Service (IPOS) that directs the provision of supports and services to be provided through the Prepaid Inpatient Health Plans (PIHP).

Meaningful PCP is at the heart of supporting beneficiary choice and control. This includes that the beneficiary is encouraged to identify individuals they wish to participate in pre-planning and formal planning events; and to invite those individuals to all planning meetings. As needed, the beneficiary, his/her parent/guardian and other individuals participating in planning and developing the IPOS, receive comprehensive and unbiased information on the array of mental health services, community resources and supports, and available qualified providers. Beneficiaries are also asked if there are other supports or accommodations needed to enable them to meaningfully participate in the process. If so, these are documented and provided. PCP planning focuses on the goals, interests, desires and preferences of the beneficiary, while still exploring and addressing an beneficiary’s needs within an array of established life domains (including, but not limited to those listed in the Michigan Mental Health Code: the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). PCP focuses on services and supports necessary for the individual to work toward and achieve their personal goals rather than being limited to authorizing the individual to receive existing programs.

(b) For children, the concepts of person-centered planning are incorporated into a family driven, youth-guided approach. A family-driven, youth-guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor beneficiaries, the beneficiary/family is the focus of planning and family members are integral to success of the planning process. As the beneficiary ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

The PIHPs are responsible for utilization management and for development and monitoring person-centered service plans and the network's implementation of the CWP services, which require additional conflict of interest protections including separation of service planning and service delivery to align with the MDHHS approved CFA&P scenarios, as outlined in the MDHHS' CFA&P requirements and PIHP contracts. In rural and/or tribal communities and as outlined in MDHHS' Conflict- Free Access and Planning "only willing and qualified provider designation" process, the State may DESIGNATE AND approve an entity to provide both service planning and direct waiver services to the same beneficiary. In those limited circumstances and as defined in MDHHS' "only willing and qualified provider designation" process, the STATE MUST PROVIDE SAFEGUARDS AND PROTECTIONS TO THE PIHPS, CMHSPS, PROVIDERS, AND AGENCIES TO BE IMPLEMENTED BY THE PIHPS, AGENCIES, PROVIDERS, AND CMHSPS to mitigate conflict of interest.

Please note that the terminology of supports coordinator and case manager are used interchangeably in this section.

(a) Who develops the plan, who participates in the process, and the timing of the plan

The plan is developed by the family with the support of a (1) supports coordinator and (2) friends, paid staff and others chosen by the family. If the family chooses to not have a supports coordinator, there are a number of alternatives available for assisting the family with the development of the IPOS. The family could also choose a supports coordinator assistant or an independent service and supports broker to help with developing the IPOS. If the family wants another provider instead of a supports coordinator or supports coordinator assistant or independent supports broker, the PIHP will assist the family to identify a provider within the network (or enroll a qualified provider upon request if possible) who possesses equal qualifications to a supports coordinator.

Qualifications: Supports coordinator assistants and independent services and supports brokers: minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator.

The child's team includes those persons most familiar with the child and family, plus service providers. The majority of team members are the parents plus family members, friends and neighbors selected by the family. The functions of the PCP team include: 1)focus on the individual's life goals, interests, desires, preferences, strengths and abilities as the foundation for planning process; 2) identification of outcomes based on the individual's life goals, interests, desires and preferences; 3) making plans for the individual to work toward and achieve identified outcomes; 4) determining the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system; and 5) developing an IPOS that directs the provision of supports and services to be provided through the Prepaid Inpatient Health Plans (PIHPs).

The family must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the final PCP meeting. Once the family has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the child's needs, changes in the child's condition as determined through the PCP process or changes in the personal preferences for support). The family and supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. The family may request and review the IPOS at any time. A formal review of the IPOS with the family, if any, shall occur not less than annually (Michigan Department of Health and Human Services, Bureau of Specialty Behavioral Health Person-Centered Planning Policy).

(b) The types of assessments that are conducted to support the service plan development process, including securing

information about participant needs, preferences and goals, and health status.

The assessment is completed adhering to the CFA&P requirements. The PCP process eliminates the need for many assessments as the child's needs, preferences, goals, and health status are determined through pre-planning and the PCP process. An assessment is conducted to determine functional eligibility for services and supports. The assessments necessary to determine level of care eligibility for the CWP are determined by the PIHP. A tool like the MichiCANS appropriate for beneficiaries with I/DD can be used to identify potential enrollees to CWP. MDHHS will begin utilizing an assessment for all beneficiaries with I/DD to identify those who may meet ICF LOC criteria to assist the PIHP/CMHSP/other subcontractor to identify potential enrollees onto the CWP. The use of this new I/DD assessment will improve the identification of beneficiaries who may have a need for CWP services prior to the formal enrollment process. In addition to the I/DD assessment, most often a psychosocial assessment is completed. Depending on the child, other assessments may be completed which include, but are not limited to: psychological, behavioral, psycho/social, speech, occupational and/or physical therapy, social/recreational, and medical evaluations. Assessment of level of care for CWP eligibility is completed by a QIDP as noted in Appendix B.

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

Once the needs of a child are identified through assessments, the family is informed of available services and that consumers have choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements to respond to the child's identified needs. This can be accomplished through several methods. The case manager, or other qualified service provider chosen by the family, can review the list of waiver services with the child, family and team. CWP services are also identified in the Michigan Medicaid Provider Manual.

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

By using the PCP process, the entire focus is on how the services and supports available in the CWP can support the child and family to achieve goals, preferences and meet needs. Health care needs (wellness and well- being) are specifically addressed through the PCP process [MDHHS Administrative Rule 330.7199].

(e) how waiver and other services are coordinated.

The supports coordinator are responsible for ensuring that the waiver services, Medicaid services, and other community services are coordinated. If the family chooses not to have a supports coordinator, supports coordinator assistant or independent supports broker, the PIHP must offer a choice of other qualified providers who can assist the family with this function.

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

Through the PCP process, the family and others at the meeting help in identifying who will be responsible for implementing and monitoring various components of the plan. The responsibilities are documented in the IPOS. The supports coordinator coordinate waiver and other services to ensure services are being delivered as indicated in the plan, the family is satisfied with their services, the child's needs are met overall and supports are effective in meeting the goals of the IPOS. If the family chooses not to have a supports coordinator, supports coordinator assistant, or independent supports broker, the PIHP must offer a choice of other qualified providers who can assist the family with this function [MDHHS Administrative Rule 330.7199]. (g) how and when the plan is updated, including when the participant's needs change. The PCP process is not only useful in the initial planning stages. It is an excellent forum for addressing changes in needs, problems in implementation, and other challenges that arise. A PCP meeting can be convened to address issues whenever the need arises and with whatever frequency is appropriate [MDHHS Administrative Rule 330.7199]. The person centered plan must be finalized and agreed to, with the informed consent of the family in writing, and signed by all individuals and providers responsible for its implementation. A copy of the plan is distributed to the family and all providers responsible for its implementation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Although a beneficiary participates in planning for services, as minors, they cannot direct services or service providers. As noted above, all individual plans of care include crisis and/or safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The beneficiary and the family define the “crisis”. The Crisis Plan provides for around-the-clock response in the community (24 hours per day, 7 days per week) and includes a safety plan that is intended to ensure the safety of the beneficiary or family members in the home.

The essential ingredients of crisis and safety plans include that the strengths, assets, interests are evident in plans; action steps to change and handle events or behavior are specified; proactive and reactive steps are identified; 24/7 response and support; long term sustainability; natural supports and community resources are used first; constant revision; documentation; strategies across environments; individualized strategies; and identification of whom to call based on skills.

The crisis plan is based on a careful review of the beneficiary's history to identify triggers of crisis. For example, a crisis might be brought on by new situations, a new route, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the beneficiary and family by community agencies, fears or worries expressed by the family, etc. For each identified crisis and safety concern both preventive and reactive strategies are identified and written into the IPOS. However, as with all aspects of the IPOS strategies are strength-based and grounded in the family's strengths and culture.

All beneficiaries enrolled in the CWP are minors living with their birth or adoptive parents or with a legal guardian who is a relative who are ultimately responsible for the care and well-being of their child. Waiver services include active treatment, training, and support to the beneficiary and relief for parents. The CWP standards include requirements that staffing meets the beneficiary's identified needs as outlined in the beneficiary's IPOS. Crisis and safety plans must identify when a beneficiary's well-being could be jeopardized when a care provider fails to show up or is unable to provide services. The IPOS must include a written plan for families to follow when issues such as provider no-shows arise; and the written plan must identify provisions for alternate arrangements for staffing services that are critical to beneficiary's well-being. While the PIHP is ultimately responsible for assuring that services identified in the IPOS are provided at a level that meets the beneficiary's needs, this responsibility initially rests with the entity providing staff, as identified in the contract with the PIHP (e.g., contractual staffing agencies).

The PCP process is the main method through which issues related to risk are identified, strategies for mitigating risk are developed, and methods for monitoring are determined. This process is described below in detail and it is effective because it involves the people most trusted and valued by the beneficiary, including family, friends and other allies. The process is an open one in which the pros and cons of alternatives can be discussed. In this manner, health and welfare issues are balanced with the beneficiary’s right to make his or her own choices. Solutions to these health, safety and welfare issues are brought up, discussed and resolved to assure the health and welfare of the beneficiary in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction. In the person-centered planning process, the beneficiary is informed of identified potential risk(s) to enable the beneficiary to make informed decisions and choices with regard to these risks. Often the discussion leads to better alternatives that both meet the beneficiary needs and satisfy his or her dreams and goals. A beneficiary may choose to address a sensitive health and welfare issue privately with the supports coordination provider, rather than within the group PCP process. Regardless of how it is done, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) has an obligation to ensure that all health and welfare issues are addressed. When the beneficiary makes a decision contrary to the recommendation of a member of his or her circle of support, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) must ensure that the beneficiary has information about all available options, documents the beneficiary choice, and revisits the issue as needed. Sometimes, a beneficiary's choices about how their supports and services are provided cannot be supported by the HSW because the choices pose an imminent risk to the health and welfare of the beneficiary or others. However, these decisions are made as part of the planning process in which the beneficiary and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the beneficiary's needs and satisfy their dreams and goals. Beneficiary-approved risk strategies are documented and written into the IPOS. Beneficiaries may be required to acknowledge situations in which their choices pose risks for their health and welfare. If the documented health or safety needs of an individual require restrictive interventions (modifications of the HCBS rule) this process will occur in the Person-Centered Planning meeting. All restrictive interventions will be written into the individual POS consistent with the requirements specified by the HCBS Final Rule and consistent with the HCBS chapter in the Medicaid Provider Manual. Back-up plans provide alternative arrangements for the delivery of services that are critical to beneficiary well-being in the event that the provider responsible for

furnishing the services fails to or is unable to deliver them. A copy of the backup plan should be provided to the beneficiary, left in the beneficiary's home, included in the beneficiary's case record, and given to applicable service providers. Back-up plans include developing lists of alternative qualified providers, using a provider agency, using informal supports, or alerting/contacting the supports coordinator when planned for services are not available. Additionally, emergency plans are developed for each beneficiary that clearly describes a course of action when an emergency situation occurs with the beneficiary. Plans for emergencies are discussed and incorporated into the IPOS during the PCP process. In an effort to make improvements in the way back-up plans are developed with beneficiaries, agencies must monitor and track situations in which back-up plans are activated, as well as when they are successful or unsuccessful. Although a beneficiary participates in planning for services, as minors, they cannot direct services or service providers. As noted above, all individual plans of care include crisis and/or safety plans. A Crisis Plan is intended to help prevent a crisis and to deal with the crisis when it occurs. The beneficiary and the family define the “crisis”. The Crisis Plan provides for around-the-clock response in the community (24 hours per day, 7 days per week) and includes a safety plan that is intended to ensure the safety of the beneficiary or family members in the home. The essential ingredients of crisis and safety plans include that the strengths, assets, interests are evident in plans; action steps to change and handle events or behavior are specified; proactive and reactive steps are identified; 24/7 response and support; long term sustainability; natural supports and community resources are used first; constant revision; documentation; strategies across environments; individualized strategies; and identification of whom to call based on skills. The crisis plan is based on a careful review of the beneficiary's history to identify triggers of crisis. For example, a crisis might be brought on by new situations, a new routine, a need for structure, or change in medication, etc. Safety issues are identified by a review of legal mandates, past knowledge of the beneficiary and family by community agencies, fears or worries expressed by the family, etc. For each identified crisis and safety concern both preventive and reactive strategies are identified and written into the IPOS. However, as with all aspects of the IPOS strategies are strength-based and grounded in the family's strengths and culture. All beneficiaries enrolled in the CWP are living with their birth or adoptive parents, legal guardian, foster parents, or living independently with supports. Waiver services include active treatment, training, and support to the beneficiary and relief for parents. The SEDW standards include requirements that staffing meets the beneficiary's identified needs as outlined in the beneficiary's IPOS. Crisis and safety plans must identify when a beneficiary's well-being could be jeopardized when a care provider fails to show up or is unable to provide services. The IPOS must include a written plan for families to follow when issues such as provider no-shows arise; and the written plan must identify provisions for alternate arrangements for staffing services that are critical to beneficiary's well-being. While the PIHP is ultimately responsible for assuring that services identified in the IPOS are provided at a level that meets the beneficiary's needs, this responsibility initially rests with the entity providing staff, as identified in the contract with the PIHP (e.g., contractual staffing agencies).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Michigan assures that each beneficiary found eligible for the Children's Waiver Program (CWP) will be given choice among service providers who are on contract with or employed by the PIHP or hired through Choice Voucher arrangements for each service included in his or her written Individual Plan of Service (IPOS). The case manager or other QIDP provides a beneficiary with a list of providers from which to choose during the pre-planning process, the IPOS development process and whenever the IPOS is updated. Some PIHPs also post provider directories on the internet. At a practical level, once a beneficiary's needs are identified and prioritized, an IPOS is created. The IPOS is grounded in assessments of the beneficiary's needs and strengths, the family's culture and preferences, and strategies designed to meet the beneficiary's/family's identified needs/strengths/preferences. Options and strategies include, but are not limited to, waiver services.

The beneficiary and family choice drives the IPOS and selection of providers. Where waiver or Medicaid State plan services are the appropriate service response, the family can choose among any willing provider who is qualified to deliver the service. Providers can be: 1) employed by, or contracted to, the PIHP; or 2) hired through Choice Voucher arrangements. In the process of service plan development, these options are discussed with families when the IPOS is established and each time the IPOS is reviewed. If the family identifies a qualified provider who is not part of the PIHP's provider network, the PIHP will contact the provider to see if he/she is willing to contract with the PIHP to provide services to the consumer; or - if the service is one that can be self-directed - to see if the provider is willing to provide services under the Choice Voucher System.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The responsibility for approving the individual plan of services (IPOS) is delegated to the PIHPs. Each PIHP develops its own process that by which it approves the IPOS that is in compliance with conflict free and MPM Policy requirements. The Michigan Department of Health and Human Services provides oversight through its MDHHS site review process AND DURING THE CWP INITIAL ENROLLMENT AND CWP RECERTIFICATION REVIEW. MDHHS RETROSPECTIVELY REVIEWS EVERY IPOS DURING THE ENROLLMENT AND RECERTIFICATION PROCESS. ONE HUNDRED PERCENT OF IPOS SUBMITTED DURING THE INTIAL ENROLLMENT PROCESS AND RECERTIFICATION PROCESS ARE REVIEWED BY MDHHS QIDP FOR COMPLIANCE. ANY DISCREPANCIES OR CONCERNS NOTED DURING MDHHS REVIEWS RESULTS IN TECHNICAL GUIDANCE BEING PROVIDED TO THE PIHP CWP LEAD.THE MDHHS SITE REVIEW TEAM CONDUCTS ANNUAL AUDITS FOR EACH PIHP TO ENSURE IPOS HAVE BEEN DEVELOPED IN ACCORDANCE WITH MDHHS PERSON- CENTERED PLANNING POLICY REQUIREMENTS, CONFLICT FREE REQUIREMENTS AND MPM POLICY REQUIREMENTS. ANY DISCREPANCIES OR CONCERNS NOTED DURING MDHHS REVIEWS RESULTS IN TECHNICAL GUIDANCE BEING PROVIDED TO THE CMHSP/PIHP AND REQUIRES CORRECTIVE ACTION TO AMEND THE IPOS TO MEET MDHHS POLICY AND STANDARDS AND REQUIRES SYSTEMIC REMEDIATIONS. PLEASE REFER TO APPENDIX H-1.A.I. FOR FURTHER DETAIL ON THE REQUIRED SAMPLING METHODOLOGY FOR PERFORMANCE MEASURES RELATED TO THIS REQUIREMENT.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

The PIHP is responsible for assuring that a written or electronic record of the beneficiary's IPOS is maintained for a minimum of three years as required by 45 CFR 92.42. Each PIHP determines the location for storing records and makes these records available for the MDHHS to review upon request.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PIHP is responsible for monitoring how the beneficiary implements services and supports, assuring that the funding is expended pursuant to the IPOS and individual budget and that risk management issues are addressed. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the beneficiary to provide these functions) will provide assistance to the beneficiary as requested or needed throughout the process of obtaining and implementing waiver services. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the beneficiary) must offer information and support to the beneficiary and directly address concerns that the beneficiary may have either over the phone or in a face to- face meeting. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the beneficiary) must have face-to-face contact with the beneficiary at the frequency specified in the IPOS. The frequency of face-to-face visits should be determined based upon the beneficiary's preference, the beneficiary's health and welfare, and other circumstances identified for that beneficiary. Continued assistance is available throughout the time that the beneficiary receives services and supports. Beneficiaries and their allies contact the supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the beneficiary responsible for this function) when new needs emerge. The backup plan would be a crisis or safety plan, in the case the crisis/safety plan is needed. The support Coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the beneficiary to provide these functions) additionally will coordinate State Plan Services that are not in the waiver.

IN THE ANNUAL SITE REVIEW PROCESS THE CLINICAL RECORDS ARE REVIEWED TO DETERMINE THAT CHILDREN/YOUTH/FAMILIES ARE AFFORDED THE CHOICE OF SERVICES AND PROVIDERS BY REVIEWING DOCUMENTATION OF SERVICE PLANNING. DURING THE IPOS/WRAPAROUND PLANNING PROCESS. THE PIHP IS RESPONSIBLE FOR MONITORING HOW THE BENEFICIARY IMPLEMENTS SERVICES AND SUPPORTS, ASSURING THAT THE FUNDING IS EXPENDED PURSUANT TO THE IPOS AND INDIVIDUAL BUDGET AND THAT RISK MANAGEMENT ISSUES ARE ADDRESSED. THE SUPPORTS COORDINATOR (OR SUPPORTS COORDINATOR ASSISTANT, INDEPENDENT SUPPORTS BROKER, OR OTHER QUALIFIED PROVIDER AS SELECTED BY THE BENEFICIARY TO PROVIDE THESE FUNCTIONS) WILL PROVIDE ASSISTANCE TO THE BENEFICIARY AS REQUESTED OR NEEDED THROUGHOUT THE PROCESS OF OBTAINING AND IMPLEMENTING WAIVER SERVICES AND NON-WAIVER SERVICES. THE SC ALSO HAS A ROLE IN COORDINATING AND LINKING THE BENEFICIARY TO OTHER HEALTH SERVICES THAT MAY OR MAY NOT BE PROVIDED BY THE BEHAVIORAL HEALTH SYSTEM TO ENSURE THE BENEFICIARY IS RECEIVING ALL MEDICALLY NECESSARY SERVICES.

NEEDS ARE DETERMINED IN MEETINGS WITH THE CHILD/YOUTH/FAMILY, THE NEEDS ARE DEVELOPED TO REFLECT WHAT IS DRIVING THE BEHAVIOR. THE NEEDS ARE ULTIZED TO DETERMINE GOALS THAT WILL ASSIST THE CHILD/YOUTH/FAMILY ACHIEVE OUTCOMES. COORDINATORS MONITOR CASES BY UTILIZING THE FOLLOWING METHODS TO ENSURE THAT WAIVER AND NON-WAIVER SERVICES, AND ANY OTHER HEALTH RELATED SERVICES ARE DELIVERED AS SPECIFIED IN THE IPOS. THESE METHODS INCLUDE BUT ARE NOT LIMITED TO IN-PERSON VISITS, FACE TO FACE CONTACTS (AUDIO-VISUAL), EMAILS, PHONE CALLS, CONTACTS WITH FAMILY, SUPPORT CIRCLE OR PROVIDERS, LETTERS OR DOCUMENTATION REVIEW. THESE MONITORING METHODS WILL ENSURE BENEFICIARIES HEALTH AND WELFARE ARE ADDRESSED AT ALL TIMES, ARE ABLE TO EXERCISE THEIR FREEDOM OF CHOICE OF PROVIDERS, HAVE ACCESS TO ALL SERVICES (WAIVER, NON-WAIVER, HEALTH, ETC.), SERVICES PROVIDED MEET THE BENEFICIARY’S NEED, AND IDENTIFIED BACK-UP PLANS ARE EFFECTIVE IF NEEDED /IMPLEMENTED TO MEET THE BENEFICIARY NEEDS. THE METHODS UTILIZED WILL BE DETERMINED THROUGH THE PERSON-CENTERED PLANNING PROCESS BASED ON WHAT IS MOST EFFECTIVE FOR THE BENEFICIARY.

EMERGENCY AND CRISIS PLANS ARE DEVELOPED FOR EACH BENEFICIARY THAT CLEARLY DESCRIBES A COURSE OF ACTION WHEN AN EMERGENCY SITUATION OCCURS WITH THE BENEFICIARY. PLANS FOR EMERGENCIES ARE DISCUSSED AND INCORPORATED INTO THE IPOS DURING THE PCP PROCESS. IN AN EFFORT TO MAKE IMPROVEMENTS IN THE WAY BACK-UP PLANS ARE DEVELOPED WITH BENEFICIARIES, AGENCIES MUST MONITOR AND TRACK SITUATIONS IN WHICH BACK-UP PLANS ARE ACTIVATED, AS WELL AS WHEN THEY ARE SUCCESSFUL OR UNSUCCESSFUL.

THE COORDINATOR WILL COMMUNICATE WITH ALL SERVICE PROVIDERS, SYSTEM PARTNERS, AND ALL OTHERS INVOLVED WITH THE CHILD/YOUTH TO SUPPORT THE FAMILY THROUGH THE USE OF

SAFETY PLANNING, REVIEWING OF PLANNING DOCUMENTS INCLUDING OUTCOMES AND STRATEGIES, AND MAKING ADJUSTMENTS TO MEET THE HEALTH AND WELFARE NEEDS OF THE CHILD/YOUTH/FAMILY. MONITORING FREQUENCY IS DETERMINED THROUGH THE PERSON-CENTERED PLANNING PROCESS AND AT A MINIMUM SHOULD BE PERFORMED ON A MONTHLY BASIS. THROUGH THE PERSON-CENTERED PLANNING PROCESS, BENEFICIARIES AND THEIR FAMILIES DETERMINE THEIR PREFERENCE AS TO WHETHER SERVICES ARE PROVIDED IN-PERSON OR VIA TELE-HEALTH. IN-PERSON FACE-TO-FACE CONTACT MUST OCCUR AT A MINIMUM OF ONCE ANNUALLY.

THE COORDINATOR WILL FACILITATE THE BROKERAGE OF SERVICES AND SUPPORTS AS IDENTIFIED THROUGH THE IPOS PROCESS WITH ALL SYSTEMS THAT ARE INVOLVED WITH THE CHILD/YOUTH/FAMILY.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

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

To include an option for the participant to choose a different entity or individual to monitor the plan;

MDHHS contract, Person-Centered Planning policy, and Self-Directed Services policy language requires PIHPs to publish a comprehensive and accessible provider directory, complete Medicaid service array, and beneficiary's rights including rights to acquire an Independent Facilitator and to engage Self-Directed Service Arrangements.

That direct oversight of the process;

In addition to regular MDHHS auditing processes, PIHPs will be contractually required to monitor OWQP Designees BY THE STATE to ensure they are implementing policies and procedures as intended. PIHPs may use authorization data, service plan audits, and grievance and appeals data to inform compliance with OWQP designations.

Regarding conducting an independent assessment of the effectiveness of monitoring or periodic evaluation by a state agency;

MDHHS evaluates the effectiveness of PIHP's beneficiary enrollment and certification process which includes a review of the service plan and verification of compliance by the PIHP of these requirements.

In ongoing auditing processes, MDHHS reviews the approved implementation plan submitted by the PIHP for compliance. Additionally, MDHHS reviews clinical records in a site review process.

MDHHS is developing reporting capabilities and integrating reporting into existing structures.

That restrict the entity that develops the plan from monitoring services without the direct approval of the state; and

Only CMHSPs/Providers with OWQP Designations BY THE STATE may be responsible for service plan monitoring and direct services to the same beneficiary. Providers/CMHSPs with OWQP Designations must attest in their OWQP Designation application there is separation between staff offering service plan monitoring and staff offering direct services.

Additionally, the PIHPs, are responsible for utilization management functions, including authorization of the service plan.

That require that agency monitoring functions be administratively separate from service provision functions.

Providers/CMHSPs with OWQP Designations must attest in their OWQP Designation application there is separation between staff offering service plan monitoring and staff offering direct services. Methods to administratively separate service monitoring from direct service must be approved by MDHHS through the OWQP Designation application process.

PIHPs must verify and monitor the adequacy of the administrative separations outlined by the CMHSP/Providers in their OWQP Designation application.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsâ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS includes services and supports that align with their assessed needs. Numerator: Number of enrolled consumers whose IPOS includes services and supports that align with their assessed needs. Denominator: All enrolled consumers sampled.

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

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

		proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS reflects their goals and preferences. Numerator: Number of enrolled consumers whose IPOS reflects their goals and preferences. Denominator: All enrolled consumers sampled.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS had adequate strategies to address their assessed health and safety risks. Numerator: Number of enrolled consumers whose IPOS had adequate strategies to address their assessed health and safety risks. Denominator: All enrolled consumers sampled.

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

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

		proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participantâs needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS changed when the individual's needs changed. Numerator: Number of enrolled consumers whose IPOS was changed when the individual's needs changed. Denominator: All enrolled consumers whose needs changed.

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

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

		proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled consumers whose IPOS are updated within 365 days of their last plan of service. Numerator: Number of enrolled consumers whose IPOS were updated within 365 days of their last plan of service. Denominator: All enrolled consumers sampled.

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

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

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of IPOS for enrolled consumers in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency. Numerator: Number of IPOS for enrolled consumers with services and supports provided as specified in the plan, including type, amount, scope, duration and frequency. Denominator: All IPOS for enrolled consumers sampled.

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

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

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of parents or legal guardians of enrolled consumers who are informed of their right to choose among the various waiver services. Numerator: Number of parents or legal guardians of enrolled consumers who are informed of their right to choose among the various waiver services. Denominator: All parents/guardians of enrolled consumers sampled.

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

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

		proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers or through Choice Voucher arrangements. Num: Number of parents/guardians of enrolled consumers who are informed of their right to choose among subcontracted providers or through Choice Voucher arrangements. Den: All parents/guardians of enrolled consumers sampled.

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: proportionate random sample, 95% confidence level
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual site reviews to ensure that Michigan's 1915(c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

Interviews are also conducted with at least one beneficiary and family whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services.

b. Methods for Remediation/Fixing Individual Problems

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

The findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns have been appropriately addressed. MDHHS utilizes information from the site review outcomes to take contract action as needed.

In those instances where an immediate need for remedial action by the PIHP on behalf of a beneficiary, that issue is addressed by CWP site review staff directly with the CWP case manager (or other qualified QIDP) and his/her supervisor to determine how to: 1) resolve the issue for that beneficiary; 2) the time frame for remediation (which, depending on the issue, may be 1-4 weeks); and 3) provide any needed technical assistance or training at the local level.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Michigan has a long history of supporting opportunities for participant self-direction that goes back to the early 1990s. These opportunities were reinforced when, in 1996, the Michigan legislature made person-centered planning a requirement for all people receiving services and supports under the Mental Health Code. Since 1997 when Michigan was awarded its Robert Wood Johnson Self-Determination demonstration grant, the Michigan Department of Health and Human Services (MDHHS) has continued to build the demand and capacity for arrangements that support self-determination. Elements of participant direction are embedded in both policy and practice from Michigan's Mental Health Code, the MDHHS Person-Centered Policy Practice Guideline and Self-Directed Services Technical Requirements and Technical Guidance, the requirements in the contracts between MDHHS and the PIHPs, and technical assistance at the state level for multiple methods for implementation by PIHPs.

While the principles of self-determination apply only to adults, the methods for implementing such arrangements were incorporated into the Childrens Waiver Program (CWP), in 2002. That year, the first version of the Choice Voucher System Technical Advisory for the Childrens Waiver Program was released.

(a) The nature of the opportunities afforded to beneficiaries

All beneficiaries served through specialty mental health are afforded the opportunity to self-direct their services. CWP families may elect employer authority or budget authority and can direct a single service or all of their services for which choice voucher is an option. Resources to support the chosen family-directed services are transferred to a Financial Management Service (FMS) provider, which administers the funds and makes payment upon authorization of the family.

Families can directly employ staff or contract with clinical providers through Choice Voucher arrangements. The responsible parent of the CWP beneficiary is the common law employer of the providers of hourly care staff and directs clinical providers through purchase of service agreements. The responsible parent delegates performance of the fiscal/employer agent functions to the FMS provider, which processes payroll and performs other administrative and support functions. The responsible parent of the CWP beneficiary directly recruits, hires and manages service providers. Detailed guidance to PIHP entities on the Choice Voucher System is provided in the Choice Voucher System Technical Advisory.

(b) How beneficiaries may take advantage of these opportunities

The Customer Services Handbook, which includes information about self-directed services, is disseminated to all people who receive mental health services and is provided at the onset of services. Information on these arrangements is also provided by the case manager (or other QIDP selected by the family) to all CWP-enrolled beneficiaries and their families – at initial enrollment and on an on-going basis. As used throughout the application, "other QIDP selected by the family" refers to the fact a beneficiary and their family cannot be required to have a case manager. The other QIDP would be a PIHP employee assigned to complete the functions identified under the Targeted Case Management (TCM) service in the MA Provider Manual. The information is provided in the context of discussing options regarding waiver services and qualified providers. Parents of CWP beneficiaries interested in pursuing arrangements that support self-direction begin the process by letting their case manager (or other QIDP) know of their wishes. Families are given information regarding the responsibilities, liabilities and benefits of beneficiary-direction prior to the person-centered planning process. A family plan of service is developed through this process with the family, case manager, and allies chosen by the family. The plan includes services and supports needed by and appropriate for the beneficiary, and identifies the waiver services the family wishes to self-direct. An individual budget is developed based on all the services and supports identified in the IPOS, and must be sufficient to implement the IPOS. The responsible parent of the CWP beneficiary can choose to use the Choice Voucher System for the identified self- directed services.

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

Through its contract with MDHHS, each PIHP is required to offer information and education to families on choice voucher. Each PIHP also offers support to beneficiaries and their families in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

While there are a number of options for families to obtain assistance and support in implementing their arrangements (e.g., independent advocacy, involvement of a network of allies - described in Section E-1-k, below) PIHPs are the primary entity that supports beneficiaries who direct their own services. Case managers, or another QIDP selected by the

family, are responsible for providing support to beneficiaries in these arrangements by working with them through the family driven youth guided planning process to develop a plan of service and an individual budget, and to assure and implement staffing back-up plans as appropriate to the beneficiary's needs. The case manager or other QIDP is responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and service arrangements. Case managers (or other QIDPs) make sure that beneficiaries and their families receive the services as identified in the IPOS and that the arrangements are implemented smoothly.

Each PIHP is required to contract with one or more financial management service providers. The FMS provider performs a number of essential tasks to support choice voucher while assuring accountability for the public funds paid to these service providers. The Financial Management Service has four basic areas of performance: function as the employer agent for beneficiaries directly employing workers to assure compliance with payroll tax and insurance requirements; ensure compliance with requirements related to management of public funds, the direct employment of workers by beneficiaries, and contracting for other authorized goods and services; facilitate successful implementation of the arrangements by monitoring the utilization of services and providing monthly invoices to the PIHP; and offer supportive services to enable families to self-direct the services and supports they need as listed in application E-1 iii-Scope of FMS.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to**

elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Although all beneficiaries are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the beneficiary or their representative. While families have the right to choose among service providers who are on contract with or employed by the PIHP or hired through Choice Vouchered services, the following three waiver services are considered provider managed services only: 1. Environmental Modification, 2. Enhanced Medical equipment and Supplies, and 3. Financial Management Services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The PIHPs are responsible for providing information about participant direction opportunities. General information about arrangements that support the Choice Voucher System is made available to all waiver families - initially and on-going - by providing them with a general brochure and with directions how to obtain more detailed information. When a parent of a beneficiary receiving waiver services expresses interest in participating in the Choice Voucher arrangements, the case manager (or other QIDP selected by the family) will assist in gaining an understanding about the Choice Voucher System, and how those options might work for the beneficiary. As used throughout the application, "other QIDP selected by the family" refers to the fact a family cannot be required to have a case manager. The other QIDP would be a PIHP employee assigned to complete the functions identified under the Targeted Case Management (TCM) service in the MA Provider Manual.

Specific options and concerns such as the benefits of choice voucher, responsibilities and potential liabilities are addressed through the family driven youth guided planning process, which is mandated in the Mental Health Code. Each family develops a Family Driven Plan of Service through the person-centered planning (PCP) process, which involves his or her family and friends and a case manager (or other QIDP). The plan developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. The PCP Policy and Practice Guideline require that health and safety concerns be addressed. The MDHHS-CWP staff provide support and technical guidance to PIHPs with developing local capacity and with implementing options for choice voucher.

(b) The PIHPs are responsible for disseminating this information to families. In addition, the program staff from MDHHS provide information and training to provider agencies, advocates and other stakeholders.

(c) This information is provided throughout the family’s involvement with the PIHP. It starts from the time that the beneficiary and his/her parent approaches the PIHP for services and is provided with information regarding options for participant direction. Parents of minor beneficiaries to be served by the CWP are to be provided with information about the Choice Voucher System. The PCP/Family Driven Youth Guided process is a critical time to address issues related to participant direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that concerns and needs are addressed. Choice Voucher arrangements begin when the PIHP and the family reach an agreement on the plan, the services authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each family who chooses to voucher services and supports on behalf of the CWP beneficiary signs a Choice Voucher Agreement with the PIHP. This agreement is one of three required agreements needed to implement Choice Voucher arrangements, and clearly defines the duties and responsibilities of the parties (i.e., the financial management service provider, the beneficiary/parent as employer or contractor of the waiver provider, and the waiver service provider himself/herself).

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☒	☒
Overnight Health and Safety Support	☒	☒
Home Care Training, Family	☐	☒
Community Living Supports	☒	☒
Therapeutic Activities	☐	☒
Home Care Training, Non-Family	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

FMS providers are procured through an RFP process and evaluated for selection through Financial Management Services Readiness Review as well as meeting the minimum operational requirements required per PIHP contract specified in 2 CFR 200, 45 CFR 92.40 and 42 CFR 438.12.
A contract between the PIHP contracted network provider and the FMS is developed and signed that outlines the roles, responsibilities, basis and process for payment. The PIHP offers the beneficiary and his/her parent or guardian (i.e., the consumer's representative) a choice among available FMS entities that meet the qualifications for this provider type. If the beneficiary's representative identifies a qualified FMS not currently on the provider panel, that FMS may apply to the PIHP to be included on the provider panel. A contract between the PIHP and the FMS is developed and signed that outlines the roles, responsibilities, basis and process for payment.

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

The FMS gets compensated via the PIHP billed monthly as a waiver service for each beneficiary. The contract between the PIHP and the FMS stipulates the conditions of the agreement including the role and responsibility of the FMS and how the FMS is compensated for the financial management services it provides.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

The FMS must designate a liaison person who will be the primary contact person and have responsibility for monitoring and ensuring that the terms of the contract between the FMS and the CMHSP are fulfilled. Activities include:

1. To receive, safeguard, manage and account for funds provided by the PIHP on behalf of each family and maintain complete and current financial records and supporting documentation verifying expenditures paid by the FMS and a chart of accounts.

2. To assist families to understand billing and documentation responsibilities.

3. To perform the financial administrative duties of employer and provide employer agent services to the family directly employing staff or contracting with clinical service providers. The FMS must abide by all federal and state laws regarding payroll taxes and shall remain current with all payroll tax requirements. Both the PIHP and the family must provide copies of all required employment documents including the Medicaid Provider Agreement to the FMS.

4. To disburse funds to vendors and other providers of services and supports as directed by each family for the services and supports selected by the family and in accordance with the family driven youth guided plan of service, only upon receipt of all required agreements including the Medicaid Provider Agreement and timesheets or invoices approved by the family as the managing Employer.

5. To maintain complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the FMS on behalf of each beneficiary and family. These records must be retained for seven years from the start of FMS services.

6. To record and maintain a monthly report of services and expenditures for each beneficiary to keep the PIHP and the family informed of utilization and expenditures for services.

7. To safeguard all confidential information including the results of any background checks, and/or other documents pertaining to providers of services as needed or requested by the family and/or the PIHP.

8. To flag for the PIHP and the family deviations in provision of services authorized in accordance with the family driven youth guided plan of services.

9. To reconcile all accrued expenses/accounts payable by the end of the fiscal year.

10. To make records regarding the choice voucher arrangement available to the PIHP (on behalf of the State Medicaid Agency) as requested and to allow each family access to their own records.

11. To commission a full financial audit of the FMS's books and records as required by the PIHP and/or MDHHS.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

  Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a) MDHHS requires that PIHP/CMHSPs develop and implement a plan for assessing and monitoring FI FMS performance that involves participants, participants' representatives and their allies in the assessment and monitoring. The plan should include a performance review process at least annually. Elements of the plan for assessing and monitoring FMS performance must minimally include:

1. Fulfillment of FMS Agreement requirements;

2. Competency in safeguarding, managing and disbursing funds;

3.Ability to indemnify the CMHSP pursuant to FMS agreement requirements;

4.Evaluation of consumer feedback and experience with and satisfaction of FMS performance with alternate methods for collecting data from beneficiaries;

5. Involvement of beneficiary and their allies in the development and implementation of the FI FMS arrangement; and

6. Performing an audit of a sample of service utilization and expenditure reports.

(b)The PIHP/CMHSPs are responsible for this monitoring. Compliance with the requirement is included in the MDHHS site review process

(c)The FMS performance review must be conducted at least annually

The PIHPs establish specific review teams to plan, implement, and conduct monitoring for 100% of their region’s contracted FMS providers. Per policy, Quality Assurance Performance Improvement (QAPI) staff schedules the reviews, site visits, coordinates all correspondence related to reviews to providers, along with sending final reports and ensuring all corrective action is reviewed and approved in a timely manner. Each review team member reviewed assigned sections of the review. QAPI combines the review documents and sends the final report draft for team approval. Once approved, the final report was sent to the FMS with requests for Corrective Action Plans, as applicable.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

Specific options for choice voucher are addressed through the family driven youth planning process. Each family develops a Family Plan of Service through the Family Driven Youth Guided process, which involves his or her family and friends and a case manager or other qualified provider (such as an independent facilitator). This planning process includes a family-driven/youth-guided practice that builds upon the beneficiary's capacity to engage in activities to promote health, safety, habilitation, skill development, and participation in community life. The process honors the preferences, choices and abilities of the beneficiary and the family and involves the participation of the beneficiary, family and friends. This process results in a plan of service for the beneficiary and family that describes the services and supports that will be used to promote health and safety and achieve the identified preferences, choices, dreams and goals.

When a parent of a beneficiary expresses interest in self-directing services, the case manager (or other person selected by the participant's representative) will assist the family in gaining an understanding about the Choice Voucher System and how those options might work for the beneficiary and family. This includes providing information regarding the responsibilities, liabilities and benefits of these options prior to the family driven youth guided planning process. The plan will include the CWP mental health services needed by and appropriate for the beneficiary. A budget is developed based on the services and supports identified in the plan and must be sufficient to implement that plan. The family will be informed of qualified financial management service providers (FMS) on contract with the PIHP.

Depending on the need of the family, case managers may provide a variety of information and assistance related to implementing participant direction by families. This can include helping to develop job descriptions and ads (in a variety of formats), and recruiting candidates to interview through job ads, worker registries and other sources. When not delegated to the FMS, the PIHP is responsible for verifying staff qualifications and working through any issues with the criminal background checks with the family. When staff are hired, the case manager may troubleshoot staff performance problems or-in the case of purchase of service arrangements for clinical service providers-the case manager may troubleshoot services, e.g., scheduling.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
Vehicle Modifications	☐
Overnight Health and Safety Support	☐
Financial Management Services	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Care Training, Family	☐
Community Living Supports	☐
Therapeutic Activities	☐
Home Care Training, Non-Family	☐
Environmental Accessibility Adaptations	☐
Specialized Medical Equipment & Supplies	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The family has the freedom to modify or terminate the arrangements for Choice Voucher at any time. The most effective method for making changes is through the person-centered/family-driven/youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement. The decision of a family to terminate choice voucher does not alter the need for services as identified in the plan. Upon termination of choice voucher, the PIHP has an obligation for assuring that all identified service needs are met by providers on contract with or employed by the PIHP. The PIHP/CMHSP must have a backup plan ready for such time that an arrangement is terminated and will encourage the family to notify the CMHSP of intent to terminate with as much forewarning as possible to help ensure proper planning for transition. Once notified of desire for termination of the arrangement The PIHP/CMHSP will ensure that health and welfare of beneficiary and services needs are met through a combination of working with the beneficiary's current staff or back up staff and coordination with the contracted provider who will be taking over service delivery. CMHSP will ensure the day of the handoff services are set up correctly and the transition was successful, typically through in person oversight by the support coordinator at time of transition.
The Self-Directed Services Technical Requirements and Self-Direction Technical Requirements Implementation Guide sets forth the procedure for the PIHP/CMHSP to follow. The Self Determination Agreement defines the responsibilities of the parties regarding participation and is in effect until it is changed or ended, as outlined in the PIHP contract and related policies regarding self-direction. Either party can initiate a change or end to the agreement by providing written notice to the other party. The PIHP/CMHSP must respond to any such notice within seven (7) working days.
Safeguards for assuring service continuity beyond planning and preparation are enforced through contract requirements.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A PIHP may terminate the choice voucher arrangement when the health and welfare of the beneficiary is in jeopardy due to the failure of the family to direct services and supports or when the family consistently fails to comply with contractual requirements.

The Self-Directed Services Technical Requirements and Self-Direction Technical Requirement Implementation Guide sets forth the procedure for the PIHP to follow. The Children's Waiver Voucher Agreement defines the responsibilities of the parties regarding participation in the Choice Voucher System and is in effect until it is changed or ended. Either party can initiate a change or end to the agreement by providing written notice to the other party. Termination of the agreement does not alter the need for services as identified in the plan and does not affect the beneficiary's right to access services through the PIHP. Upon termination of choice voucher, the CMHSP has an obligation for assuring that all identified service needs are met by providers on contract with or employed by the PIHP. In any instance of discontinuation or alteration of an arrangement, the local grievance procedure process will be used to address and resolve the issues, as outlined in the PIHP contract and related policies regarding self-direction. The PIHP/CMHSP will ensure that health and welfare of beneficiary and services needs are met through a combination of working with the beneficiary's current staff or back up staff and coordination with the contracted provider who will be taking over service delivery. CMHSP will ensure the day of the handoff services are set up correctly and the transition was successful, typically through in person oversight by the case manager at time of transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		135
Year 2		159
Year 3		174
Year 4		198
Year 5		219

Appendix E: Participant Direction of Services

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

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

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

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

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

In the Agency Supported Self-Direction model, participants serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (described in this document as ASSD provider) is contracted with the PIHP/CMHSP and serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing workers compensation insurance). In the Supported Self-Direction model, participants may get help with selecting their workers (for example, the ASSD provider may have a pool of workers available for consideration by participants). The ASSD provider may also provide back-up workers when the participants regular worker is not available. Like traditional staffing agencies, the ASSD provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that participants directly employing workers may not be able to provide. The Agency Supported Self-Direction model is also an important option for participants who do not want to

directly employ workers or who want to transition into direct employment. An FMS provider agency would only be used in ASSD arrangements if the beneficiary were also using budget authority and acting as an employer agent or when using a purchase of services agreement to hire an ASSD provider who is not in the PIHP impaneled network.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Not applicable. Same as c-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☒ **Other**

Specify:

The FMS provider is responsible for conducting criminal background checks and abuse screenings for directly employed providers. The cost is built into their monthly fee. Refer professional staff to FMS for personal services contract. Terminate personal services contract with unsatisfactory professional staff.

Appendix E: Participant Direction of Services

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in**

Appendix C-1/C-3

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

1. Identify clinical service providers and refer to the FMS.
2. Execute and terminate purchase of service agreements with clinical service providers.
3. Authorize payment for contracted clinical service providers.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An individual budget is a robust reflection of how the beneficiary and family have chosen to allocate their funds to purchase the supports and services of their choice that they need to meet the goals in their plan. They should be invested in their plan and budget to allow them to achieve their vision of living an inclusive, productive, autonomous life. Both the plan and the individual budget are developed in conjunction with one another through the person-centered/family-driven/youth-guided planning process. Both the beneficiary and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the beneficiary and family. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the beneficiary is using to obtain the services and supports. Those arrangements are also determined primarily through the family driven youth guided process.

A simple methodology using reliable cost estimating information is used to develop the budget. This is called the Estimated Cost of Services (ECOS) which is included in every IPOS. Each budget is the sum of the units of service multiplied by the period covered, multiplied by the rate for the service as agreed upon by the participant and authorized through the IPOS. The state does not set a uniform rate for each service. This formula allows each self-directed employer to set a wage for their employees within the limits of their budget. Typically, when an existing person-centered service plan is transitioned to an arrangement which supports self-determination, the overall budget is not more than the costs of delivering the services under the previous traditional service plan.

This ECOS is consistently applied to each plan for every beneficiary and gives the beneficiary a baseline for their budget. Through the person-centered planning process, the beneficiary and their team decides how they will utilize the medically necessary dollars to purchase their unique services and supports. The estimated budget in this planning period is based off of assessed need of each beneficiary and cost is set at the rate that would have been used based on the beneficiary's acuity level for each medically necessary service. The details of this constant approach is publicly available can be found in the Self-Direction Technical Requirement Implementation Guide which is published on the MDHHS website. The ECOS is developed through the rates set by each CMHSP for each provider. The ECOS is the total amount of funds used for the current services and that total of funds that must be available for the person's use for planning and developing their individual budget. (must be robust enough to have resources to follow FLSA laws, cover employer agent and other admin)

Michigan uses a retrospective zero-based method for developing an individual budget. The amount of the individual budget is determined by costing out the services and supports in the plan, after that plan meets the beneficiary's needs and goals have been developed. In the plan, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year) to match the period of the family-driven youth-guided plan.
Once the plan is developed, the amount of funding needed to obtain the identified services and supports is determined collectively by the family, the mental health agency (PIHP or designee), and others participating in the PCP/family-driven/youth-guided process.
This process involves costing out the services and supports using the rates for providers chosen by the beneficiary and the number of hours authorized in the plan. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Worker's Compensation Insurance and be equitable to the established CMH rates for the same service when not vouchered. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS.
Beneficiaries must use a financial management service if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a family chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a financial management service be used.
Financial management service is a waiver service and is available to any participant using an arrangement that supports self-determination. Each PIHP develops a contract with the financial management services (FMS) and sets the rate and costs for the services. Actual costs for the FMS will vary depending on the family's needs and usage of FMS, as well as the negotiated rate between the PIHP and financial management service.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Materials provided by the PIHP include written information on the development of the individual budget. During the planning process, a beneficiary is to be provided clear information and explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the beneficiary during individual budget implementation. Found in the Estimated Costs of Services, which is a contractual requirement for every IPOS whether the beneficiary chooses to self-direct their services or not.

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the IPOS, using the PCP process, or is determined as applied to a pre-existing, sufficient IPOS, using the PCP process. Budget authorization is contingent upon the beneficiary and the PIHP entity reaching agreement on the amount of the budget and on the methods that will, or may, be applied by the beneficiary to implement the plan and the individual budget. The budget will be provided to the beneficiary in written form, as an attachment to the Self-Determination Agreement that outlines the expectations and obligations of the participant and the PIHP. The beneficiary's plan is also attached to the agreement.

The beneficiary's targeted case manager or QIDP (or other qualified provider selected by the participant) are expected to provide assistance to the beneficiary in understanding the budget and how to utilize it. In situations where the beneficiary also has an independent supports broker, the broker will assist the beneficiary to understand and apply the budget. The beneficiary may seek major adjustments to the individual budget that would mean a increase in medically necessary support by requesting this from their targeted case manager or other chosen qualified provider. The targeted case manager or QIDP (or other qualified provider selected by the participant) will be expected to assist the beneficiary to convene a meeting including the beneficiary's chosen family members and allies, and to assure facilitation of a PCP process to review and reconsider the budget. A change in the budget is not effective unless the beneficiary and the PIHP have agreed to the changes. The CMHSP must inform beneficiaries as to how, when, and what kind of changes they can make to their individual budget without support coordinator approval and when such changes require approval. The mental health agency (PIHP or designee) must provide the beneficiary with information on how to request a Medicaid Fair Hearing when the beneficiary's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of the budget adjustment. Information on how to request a Fair Hearing is attached to every IPOS and a copy of that IPOS is distributed to each beneficiary as mandated.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The amount of the individual budget must be sufficient to provide a defined amount of resources. It must also be written to allow flexibility in its use, which means that a beneficiary can decide when services and supports are used and make some adjustments between budget line items.
Adjustments that do not require a Modification to the Individual Budget: Unless an adjustment deviates from the goals and objectives in the beneficiary's plan, the family is not required to obtain permission from the mental health agency (PIHP or designee) or provide advance notification of an intended adjustment. The plan must be written in a way that contemplates and plans for the manner in which the beneficiary and family may use the services and supports. Amounts, scopes and durations may be written in a length of time that makes flexibility possible (a month or a quarter). Services and supports that are similar and may be substituted for one another should be identified as well as services and supports for which there is no substitution.

Adjustments in this manner should be communicated to the mental health agency (PIHP or designee) in a timely manner. Adjustments that Require a Modification to the Individual Budget: Sometimes, a participant wants to make an adjustment that fundamentally alters the plan (for example, substituting one service for another service that is not similar, forgoing services and supports, or using services and supports not authorized). If the adjustment does not serve to accomplish the direction and intent of the beneficiary's plan, then the plan must be appropriately modified before the adjustment may be made. In this situation, a modification can often be made over the phone between the family and his or her targeted case manager, TCM assistant, or independent supports broker (or other qualified provider selected by the beneficiary). The change should be accomplished as expeditiously as possible. Larger changes may need to be made through the PCP process.

The mental health agency (PIHP or designee) must provide the beneficiary with information on how to request a Medicaid Fair Hearing when the beneficiary's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of the budget adjustment.

If the beneficiary is opting to make changes that do not affect the overall limit of the budget and will be essentially moving funds from one line item to another in order to adjust amount, scope, duration of supports outlined in the budget, the beneficiary can work with their FMS entity to make and document those changes. The supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the beneficiary) will be notified and expected to make adjustments to the IPOS for clarification on the new expected amount, scope and duration in the budget for purposes of oversight that services were rendered as indicated in the plan.

Unless an adjustment deviates from the goals and objectives in the beneficiary's IPOS, the beneficiary is not required to obtain permission from the mental health agency (PIHP or designee) or provide advance notification of an intended adjustment. The IPOS must be written in a way that contemplates and plans for the manner in which the participant may use the services and supports. Amounts, scopes and durations are written in length of time that makes flexibility possible (a month or a quarter). Services and supports that are similar and may be substituted for one another should be identified as well as services and supports for which there is no substitution. Adjustments in this manner should be communicated to the mental health agency (PIHP or designee) in a timely manner.

Sometimes, a participant wants to make an adjustment that fundamentally alters the IPOS (for example, substituting one service for another service that is not similar, forgoing services and supports, or using services and supports not authorized). If the adjustment does not serve to accomplish the direction and intent of the person's IPOS, then the IPOS must be appropriately modified before the adjustment may be made and must be done through the PCP process then agreed upon through that process by both the beneficiary and the CMHSP.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be

associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Beneficiaries must use a financial management provider if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs.

The funds in an individual budget are transferred to the financial management provider, which handles payment for services and supports in the plan upon receipt of invoices and timesheets authorized by the family. The financial management provider provides both the beneficiary and the mental health agency (PIHP or designee) a monthly report of expenditures and flags expenditures that are over or under the expected amount by ten percent or more. This report is the central mechanism for monitoring implementation of the budget. Over- or underutilization identified in the report can be addressed by the targeted case manager (or other chosen qualified provider) and beneficiary informally or through the PCP/family driven youth guided process.

The targeted case manager or QIDP (or other chosen qualified provider) is responsible for assisting the beneficiary in implementing the individual budget and arrangements, including understanding the budget report. A beneficiary can use an independent supports broker to assist him or her in implementing and monitoring the plan and budget. When a beneficiary uses an independent supports broker, the targeted case manager or QIDP (other qualified provider selected by the beneficiary) has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the authorization and monitoring the plan and individual budget cannot be delegated to an Independent Supports Broker by the PIHP or designee.

Through the FMS, the targeted case manager or QIDP (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact they have with the beneficiary, the targeted case manager or QIDP (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The State has established a grievance system that is compliant with 42 CFR 431 Subpart F through contract agreement with each PIHP. The Grievance and Appeal Technical Requirement is within the MDHHS/PIHP contract. The state agency that operates the dispute mechanism is Michigan Office of Administrative Hearings and Rules (MOAHR).

The notice of action to the beneficiary or his/her legal representative must be in writing and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

The PIHPs are required to provide timely and adequate notice of any Adverse Benefit Determination. The content of the notice must meet the following requirement:
- Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;
- Description of Adverse Benefit Determination;
- The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
- Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
- Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;
- Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
- Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";
- Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
- An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

The Adverse Benefit Determination Notice allows for the opportunity for internal review with the PIHP prior to the beneficiary requesting a State Fair Hearing in some situations.
- The PIHP provides this Notice to the beneficiary when denying a requested service that is not already in place. This is effective on the decision date.
- The Adverse Benefit Determination Notice is also used when terminating, suspending, reducing a service that is in place, and is provided to the beneficiary 10 days before the effective date, unless there is an exception.
- As long as a written request is received before the effective date, services remain in place until the Notice of Resolution is sent to the beneficiary. If a determination is being made or action is being taken based upon suspect of fraud, the Adverse Benefit Determination Notice is sent to the beneficiary but may only be sent 5 days before the effective date.

Appeal Resolution Notice:
- The notice of resolution must include the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:

i. Right to request a state fair hearing, and how to do so;
ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

If a beneficiary not enrolled in the CWP requests to apply for the CWP, the beneficiary must be given the choice of home and community-based waiver services as an alternative to the level of care provided in an ICF/IID by the PIHP. Evidence that the PIHP offered this choice to the beneficiary is documented in the CWP certification form. If the PIHP does not offer the choice between home and community-based services instead of the level of care offered by an ICF/IID, the PIHP must give adequate notice to the beneficiary or legal representative (if applicable) per the process described above.

In unique circumstances where the PIHP submits CWP applications to MDHHS for review, if the beneficiary is determined to not meet eligibility requirements for the CWP, an adequate notice is sent to the beneficiary and legal representative (if applicable) by the MDHHS. This notice follows the process described above.

Once a beneficiary has enrolled in the CWP, the beneficiary may receive adequate or advance notice, depending on the decision related to their CWP or other Medicaid mental health services.

Upon completion of the development of the individual plan of services (IPOS) through the person-centered planning process, the

beneficiary or his legal representative is provided adequate notice of action at the time of the signing that he or she may file a request for a fair hearing if he or she subsequently disagrees with the scope, duration or intensity of authorized services. Adequate notice of action is also provided when there is a decision by the PIHP to deny or limit authorization for services requested. Notice is provided to the beneficiary or his/her legal representative on the same date as the action takes effect. CMHSP provider will explain that services will continue as listed in the IPOS until ruling on the appeal.

PIHP policies and procedures vary as to upon whom the responsibility is placed to notify beneficiaries or their legal representatives of an adverse action, e.g. Utilization Management, Customer Services, person designated in the plan of service as responsible for assuring that committed services/supports are delivered. (MDHHS Admin. Rule 330.7199)

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy. The MDHHS also monitors Fair Hearing Requests and Decisions by the Tribunal for beneficiaries and takes action with the PIHP when necessary to assure waiver services are provided as specified in policy.

All notices of action which include information on the opportunity to request a State fair hearing are maintained in appropriate PIHP administrative files and a copy in the beneficiary's record.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a) The State has established a grievance and appeals system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 10 PIHPs. The Appeal and Grievance Resolution Processes Technical Requirement of the MDHHS/PIHP Contract is applicable to all the PIHPs, the CMHSPs, and their provider networks.
b) Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, (e.g., denial, termination, or reduction of a service), and those challenging anything else, (e.g., beneficiary's dissatisfaction with service, quality of care or services provided or aspects of interpersonal relationships between a service provider and the beneficiary). A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

BENEFICIARY APPEALS: Beneficiary Appeals are initiated by notice of an adverse benefit determination (ABD) (action). Upon receipt of an ABD notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:
1. The Enrollee has 60 calendar days from the date of the notice of ABD to request an Appeal. 42 CFR 438.402(c)(2)(ii).
2. The Enrollee may request an Appeal either orally or in writing. Oral inquiries seeking to Appeal an ABD are treated as appeals.
3. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee’s benefits if all of the following occur: The enrollee files the request for an appeal timely within 60 calendar days from the date on the ABD Notice; the enrollee files for continuation of benefits timely (on or before the latter of within ten (10) calendar days of the PIHP sending the notice of ABD; or the intended effective date of the proposed ABD; and the period covered by the original authorization request has not expired.

PIHP Responsibilities when the Enrollee Requests Appeals-The PIHP must:
1. Provide any reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capability.
2. Acknowledge receipt of an expedited Appeal within 72 hours of receipt. The PIHP must acknowledge receipt of each standard Appeal within five (5) business days.
3. Maintain a record of appeals for review by the State as part of its quality strategy.
4. Ensure that the individual(s) who make the decisions on appeals are individuals: Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; who when deciding an Appeal that involves either involves clinical issues, or a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the enrollee’s condition or disease; and consider all comments, documents, records, and other information submitted by the enrollee and/or their representative without regard to whether such information was submitted or considered in the initial ABD.
5. Provide the enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. The PIHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals.
6. Provide the enrollee and the enrollee’s representative the enrollee’s case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP, in connection with the Appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
7. Provide opportunity to include as parties to the Appeal the enrollee and the enrollee’s representative or the legal representative of a deceased enrollee's estate.
8. Provide the enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one. The enrollee can request a State Fair Hearing only after receiving notice that the PIHP is upholding the ABD. In the case of a PIHP that fails to adhere to the notice and timing requirements of 30 days, the enrollee is deemed to have exhausted the PIHP’s appeals process. The enrollee may initiate a State fair hearing.

Appeal Resolution Timing and Notice Requirements:
1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days from PIHP receipt of the Appeal.
2. Expedited Appeal Resolution (timing):

a) Each PIHP must establish and maintain an expedited review process for appeals when the PIHP determines (for a request from the enrollee) or the provider indicates (in making a request on the enrollee's behalf or supporting the enrollee's request) that the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
b) The PIHP may not take punitive action against a provider who requests an expedited resolution or supports the enrollee's Appeal.
c) If a request for expedited resolution of an appeal is denied, the PIHP must: Transfer the Appeal to the timeframe for standard resolution, make reasonable efforts to give the enrollee prompt oral notice of the denial if the PIHP extends the timeframes not at the request of the enrollee, within two (2) calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision and resolve the Appeal as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days.
d) If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72 hours after the PIHP receives the request for expedited resolution of the Appeal.

Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to 14 calendar days if the enrollee requests or if the PIHP shows (to the satisfaction of the State, upon its request) that there is a need for additional information, and how the delay is in the enrollee's interest.

Appeal Resolution Notice: The PIHP must provide Enrollees with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's right to request a State Fair Hearing, and how to do so and the right to request to receive benefits while the State Fair Hearing is pending, and how to make the request; and the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's ABD.

BENEFICIARY GRIEVANCES: Medicaid beneficiaries have the right to a local grievance process for issues that are not "actions". Generally, the enrollee must file a Grievance with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances. A Grievance may be filed at any time by the enrollee, guardian, or parent of a minor child, or the enrollee's authorized representative.
For each grievance filed by a beneficiary, the PIHP is required to:
1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability.
2. Acknowledge receipt of the Grievance within 5 business days.
3. Maintain a record of grievances for review by the State as part of its quality strategy.
4. Ensure that the individual(s) who make the decisions on the Grievance are individuals: Who were neither involved in any previous level review or decision-making, nor a subordinate of any such individual, who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues and who consider all comments, documents, records, and other information submitted by the enrollee and/or the enrollee's representative without regard to whether such information was submitted or considered previously.

Timing of Grievance Resolution: Provide the enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP received the Grievance.

Extension of Timeframes: The PIHP may extend the Grievance resolution and notice timeframe by up to 14 calendar days if the enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the enrollee's interest. If the PIHP extends resolution/notice timeframes not at the request of the enrollee, it must make reasonable efforts to give the enrollee prompt oral notice of the delay and within 2 calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision.

STATE FAIR HEARING PROCESS:
A. Federal regulations provide the enrollee the right to an impartial review by a State-level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, after receiving notice that the PIHP is upholding an ABD after Appeal and when the PIHP fails to adhere to the notice and timing requirements for resolution of appeals as

described in 42 CFR 438.408(f)(1)(i).
B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions of the review are met: Must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing; must be independent of both the State and the PIHP, must be offered without any cost to the enrollee, must not extend any of the required timeframes and must not disrupt the continuation of benefits.
C. The PIHP may not limit or interfere with the enrollee's freedom to make a request for a State Fair Hearing.
D. The enrollee is given no more than 120 calendar days from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing.
E. The PIHP is required to continue benefits if the conditions described in Section VII - Medicaid Services Continuation or Reinstatement are satisfied and for the duration described therein.
F. If the enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the ABD.
G. The parties to the State Fair Hearing include the enrollee and the enrollee's representative, or the representative of a deceased enrollee's estate, and the PIHP. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
H. Expedited hearings are available.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The MDHHS requires reporting on the following critical incidents, immediate reportable events, sentinel event analysis and allegations of abuse, exploitation, and neglect. All critical incident and immediate reportable events are reported through the Customer Relationship Management (CRM) system. Allegations of abuse, exploitation, and neglect are reported to the local Community Mental Health Services Program (CMHSP) Office of Recipient Rights (ORR).

CRITICAL INCIDENT REPORTING AND IMMEDIATE REPORTABLE EVENTS:
MDHHS oversees all critical incidents and immediate reportable events through the CRM to monitor this reporting as incidents/events are submitted for trends, outliers and issues. Review includes requesting and reviewing of required remediations which provide individual (if applicable) and/or systemic responses to prevent reoccurrence. The system allows for MDHHS to ensure the PIHP's process for reporting these incidents and events is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would require submission of a corrective action plan by the PIHP. The corrective action plan effectiveness submitted by the PIHP will be reviewed by MDHHS during ongoing reviews of critical incident reports and event reporting when submitted. MDHHS requires the PIHPs and CMHSPs to report critical incident data and related information into the CRM as a measure of how well the PIHP/CMHSP and its contracted providers monitor the care of vulnerable service recipients, including CWP beneficiary. The Critical Incident Reporting System (CIRS) through the CRM enables MDHHS to receive data on beneficiaries within specified timeframes, depending on the type of event. People enrolled under the CWP are a reportable population in the CIRS. CIRS requires the PIHP to report the following events to MDHHS: suicide, non-suicide death, emergency medical treatment due to injury, falls or medication error, hospitalization due to injury, falls or medication error, and arrest of beneficiary. Timeframes for reporting the five specified events in the CIRS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a “best judgment” determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this “best judgment” determination occurred.

Non-suicide death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the CMHSP attempts to determine whether the death was due to suicide. In that case the submission is due within 30 days of the end of the month in which CMHSP determined the death was not due to suicide.

Emergency medical treatment due to injury, fall or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization due to injury, fall or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Arrest: Due within 60 days after the end of the month in which the arrest occurred.

Definitions for Critical Incident Reporting System (CIRS):
- Suicide: A Beneficiary’s death shall be reported as a suicide when either one of the following two conditions exists:

1. The CMHSP serving the beneficiary determines, through its death review process, that the beneficiary’s death was a suicide, or
2. The official death report (i.e., coroner’s report) indicates that the beneficiary’s death was a suicide

- Non-suicide Death: Any death, for beneficiary in the reportable population, that was not otherwise reported as a suicide. The reportable population includes any CWP beneficiary.
- Emergency Medical Treatment due to Injury, Fall or Medication Error: Situations where an injury to a beneficiary, injury due to a beneficiary fall or a medication error results in face-to-face emergency treatment being provided by medical staff. Any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms should be reported, provided the treatment was sought due to an injury, fall or medication error.
- Hospitalization due to injury, fall or medication error: Situations where an injury to a beneficiary, injury due to a beneficiary fall or a medication error results in hospitalization of the beneficiary. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.
- Fall: Defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.
- Medication error: Defined as a situation where a mistake is made when a beneficiary takes prescribed medication (i.e., incorrect dosage taken, prescription medication taken that is not prescribed, medication taken at wrong time, medication used improperly), or a situation where non-prescription medication is taken improperly.

• Injury: Defined as bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body. Examples of injuries include bruises (except those due to illness), contusions, muscle sprains, and broken bones.
• Arrest: Situations where a beneficiary is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a beneficiary is transported for the purpose of receiving emergency mental health services, or situations where a beneficiary is held in protective custody, are not considered to be an arrest.

The MDHHS/PIHP contract requires the PIHP to report immediate reportable events into the CRM when any of the following egregious events occur:
• Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation (report within 48 hours of death or PIHP's notification of death),
• relocation of a beneficiary's placement due to licensing suspension or revocation (report to MDHHS within five business days),
• conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of his or her job duties or responsibilities (report to MDHHS within five business days)
• an occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours (report to MDHHS and
• Critical Incidents which may be newsworthy or represent a community crisis must be reported immediately.

SENTINEL EVENT

A Sentinel Event is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The PIHP or delegated provider must prepare and file critical incident reports that include the following components:
i. Provider determination whether critical incidents are sentinel events.
ii. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.
iii. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.

OFFICE OF RECIPIENT RIGHTS

Allegations of abuse (including exploitation) and neglect are reported to the local CMHSP ORR through the incident report forms and/or recipient rights complaint forms. Any person employed by the MDHHS, each CMHSP, each licensed hospital, and each service provider under contract with the department, such as a PIHP or any of its subcontractors, has a duty to report any suspected abuse and/or neglect to the local ORR. Michigan law and rules require the mandatory reporting of recipient rights complaints in a timely manner to the CMHSP ORR. CMHSP policies further specify that reports of rights violations are immediately reported to their ORR. Reporting may be done in writing or by phone or by other means of communication, such as fax. If the ORR substantiates a rights violation related to abuse, including exploitation or neglect, the ORR makes a recommendation for remediation to the CMHSP director. the local CMHSP ORR reporting to other state agencies, such as the Department of Licensing and Regulatory Affairs, Child Protective Services (CPS), or Adult Protective Services (APS), and involvement by local law enforcement.

Certain situations involving suspected abuse and neglect must also be reported to law enforcement, CPS or APS. The Michigan Mental Health Code requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) "immediately shall make or cause to be made, by telephone or otherwise, an oral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police. Within 72 hours after making the oral report, the reporting individual shall file a written report with the law enforcement agency to which the oral report was made, and with the chief administrator of the facility or agency responsible for the recipient (330.1723)." Michigan's Child Protection Law requires the following with regard to reporting suspected child abuse or neglect to MDHHS CPS for mandatory reporters,

which would include employees or contractors of the mental health system providing waiver services: (the reporter) “immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this Act (722.623).” Michigan’s Social Welfare Act requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) “who suspects or has reasonable cause to believe that an adult has been abused, neglected, or exploited shall make immediately, by telephone or otherwise, an oral report to the county department of social services of the county in which the abuse, neglect, or exploitation is suspected of having or believed to have occurred. After making the oral report, the reporting person may file a written report with the county department [400.11(a)].”

OTHERS: Other agencies, such as law enforcement, protective services, or licensing, may receive reports of allegations of abuse, neglect, and exploitation. Where beneficiaries live in licensed settings, Michigan law and rules (for example, R 400.14311 for small and large licensed AFC homes) require licensee to complete an Incident/Accident Report; a copy of which is forwarded to the CMHSP ORR, CMHSP and responsible agency) which would assure the immediate health and welfare of the beneficiary, as well as that of any other mental health recipients in the home.
The report includes the following:
1. A licensee shall make a reasonable attempt to contact the resident’s designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident’s designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:
a) The death of a beneficiary.
b) Any accident or illness that requires hospitalization.
c) Incidents that involve any of the following:
i. Displays of serious hostility
ii. Hospitalization.
iii. Attempts at self-inflicted harm or harm to others.
iv. Instances of destruction to property.
d) Incidents that involve the arrest or conviction of a beneficiary as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
2. An immediate investigation of the cause of an accident or incident that involves a beneficiary, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
3. If a resident is absent without notice, the licensee or direct care staff shall do both of the following:
a) Make a reasonable attempt to contact the resident’s designated representative and responsible agency.
b) Contact the local police authority.
4. A licensee shall make a reasonable attempt to locate the resident through means other than those specified in subrule (3) of this rule.
5. A licensee shall submit a written report to the resident’s designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
6. An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. “Incident” means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
a) The name of the person who was involved in the accident or incident.
b) The date, hour, place, and cause of the accident or incident.
c) The effect of the accident or incident on the person who was involved and the care given.
d) The name of the individuals who were notified and the time of notification.
e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.
f) The corrective measures that were taken to prevent the accident or incident from happening again.
7. A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

DEFINITIONS:
Definitions of Abuse and Neglect (MDHHS Administrative Rule 330.7001):

Abuse is divided into three categories, Abuse Class I, Abuse Class II and Abuse Class III. Neglect is also divided into

three categories, Neglect Class I and Neglect Class II and Neglect Class III. Abuse Class I and II and Neglect Class I and II are required to be reported to MDHHS on a semi-annual basis as each involves some level of physical or emotional harm to the recipient or involves sexual abuse.

Abuse class I means a nonaccidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient. "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Sexual abuse means any of the following:
i. Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
ii. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
iii. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
Sexual contact means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in asexual manner for any of the following:
i. Revenge.
ii. To inflict humiliation.
iii. Out of anger.

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

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

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

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

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

Neglect class II" means either of the following:
i. Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service and that cause or contribute to non serious physical harm or emotional harm to a recipient.
ii. The failure to report apparent or suspected abuse Class II or neglect Class II of a recipient.

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

Every recipient of public mental health services in Michigan and his/her legal representatives receive a booklet developed by MDHHS entitled “YOUR RIGHTS When Receiving Mental Health Services in Michigan” at the time of admission into services and periodically thereafter. The CWP beneficiary’s case manager will provide information concerning protections from abuse, neglect, and exploitation, including how to notify authorities, at the onset of CWP services and as often as needed by the beneficiary or the informal caregivers, but at least annually during a person-centered planning meeting. This is in accordance with Section 330.1706 of the Code: “… applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients. From Rule 330.7011: A note describing the explanation of the materials and who provided the explanation shall be entered in the recipient's record. The required notification/explanation includes explicit, detailed coverage of the Code mandated protections from abuse, neglect, and exploitation, and the how beneficiaries (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the beneficiaries may have experienced abuse, neglect or exploitation.

Chapter 7 of the Michigan Mental Health Code also requires that every CMHSP ORR must assure that all program sites, whether directly operated or through contract with the CMHSP, have rights booklets available in public areas for beneficiaries, guardians, caregivers, etc. The booklet describes the various rights afforded the beneficiary under the U.S. Constitution, Michigan Constitution, the Michigan Mental Health Code and MDHHS Administrative Rules as well as contact information for the CMHSP ORR if the beneficiary, legal representative, or anyone on behalf of the beneficiary feels that the beneficiary's rights have been violated, including the right to be free from abuse or neglect.

The MDHHS/PIHP contract requires that each PIHP must have a Customer Services Unit that provides information about mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a beneficiary. The Customer Services Unit may also, upon request of the beneficiary, assist with contacting the local Office of Recipient Rights for assistance with an issue related to abuse, neglect or exploitation.

The ORR also houses a Training Unit to ensure that recipient rights initiatives are consistently implemented statewide. In addition to training staff of CMHSPs and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients’ rights. CMHSP ORRs conduct rights informational sessions for beneficiaries, family members, advocates and interested others. Additionally, the MDHHS holds annual Recipient Rights, Beneficiary, and Home and Community Based Waiver Conferences, all of which include beneficiaries and/or their families. These conferences provided Recipient Rights training that describe beneficiary rights and the complaint resolution and appeal process.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical incidents may be investigated by the CMHSP ORR, the PIHP, the CMHSP, as well as by law enforcement or other state agencies as applicable depending on the nature of the incident.
EVENT REPORTING: The MDHHS/PIHP Contract, following event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service. The written report will include beneficiary information, date, time and place of death (if in a foster care setting, the foster care license #), final determination of cause of death (from coroner's report or autopsy), summary of conditions (physical, emotional) and treatment or interventions preceding death, any quality improvement actions taken as a result of an unexpected or preventable death, and the PIHP's plan for monitoring to assure any quality improvement actions are implemented.

SENTINEL EVENT: The PIHP, or its CMHSP affiliate with delegated responsibility, must review the incident to determine if it meets the criteria and definitions for sentinel events and are related to practice of care. Depending on the type of incident, it may also be required to report on the CIRS to MDHHS. The MDHHS/PIHP contract, requires that each PIHP's Quality Assessment Performance Improvement Plan (QAPIP) addresses sentinel events. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

All unexpected deaths (deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect) of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:
- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

Per the MDHHS/PIHP Contract, physical management, permitted for intervention in emergencies only, is considered a critical incident that must manage and reported according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined as "a technique used by staff to restrict the movement of a beneficiary by direct physical contact in order to prevent the beneficiary from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the beneficiary or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan." Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The MDHHS requires PIHPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the PIHP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated.

CRITICAL INCIDENT REPORTING SYSTEM in the CRM: The CIRS in the CRM requires the PIHPS and CMHSPs to report the following events to MDHHS: suicide, non-suicide death, emergency medical treatment due to injury, fall or medication error, hospitalization due to injury, fall or medication error, and arrest of beneficiary. PIHPs/CMHSPs will submit reports directly (through Application Programming Interface) into the CRM. Incidents reported in the CRM would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. Additionally, some of the incidents reported in the CRM such as a death or injury, could result in a criminal investigation or referral to Child or Adult Protective Services. MDHHS staff review incidents that are considered priorities as they are reported, such as certain types of deaths (suicide and accidental deaths for example) and injuries (related to the use of restrictive interventions or medication errors for example). This allows MDHHS to request

more immediate corrective action and response to these priority incidents. PIHPs have 30 days to respond to remediations generated by priority incidents reported or those requested by MDHHS staff. The CRM allows for MDHHS to monitor for trends, outliers, and issues more closely and in real time. In addition, the CRM allows for CMHSPs/PIHPs to indicate whether CPS, APS LARA AFC Licensing or ORR investigations have been opened to investigate the incident. CMHSPs/PIHPs are also able to identify those incidents reported which have been determined a Sentinel Event. Section G-1-b of this application defines incidents and identifies timelines for reporting to the state.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP affiliates of the PIHPs shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the office shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the beneficiary within five days acknowledging receipt of the complaint and then provides written updates every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report of the investigation including the conclusion of the office of recipient rights and the action or plan of action to remedy a violation to the complainant, recipient if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights. Information gathered from investigations is reviewed for trends and becomes a focus of the on-site visitation conducted by MDHHS to CMHSPs. Aggregate data are shared with MDHHS, the Quality Improvement Council (QIC) and Federal Compliance staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

OTHER: In the event of a reported incident of a child or adult, MDHHS – CPS or APS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring beneficiary safety. The CMHSP ORR is responsible for investigating rights violations. The Department of Licensing and Regulatory Affairs is responsible for investigating licensing rule violations. Law enforcement may also be conducting an investigation related to possible criminal activity in conjunction with the above. Local DHS offices must have signed agreements with their respective CMHSP boards and AFC licensing to cover roles and responsibilities for handling APS investigations in mental health settings. The protocol for joint operating agreements and the model agreements for this coordination for reporting, investigating, and sharing information are in the Adult Services Manual (DHS-ASM 256).

If, during a MDHHS site visit, the site review team member identifies an issue that places a beneficiary in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

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

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

CRITICAL INCIDENT REPORTING SYSTEM in the CRM: PIHPs/CMHSPs will submit reports directly (through Application Programming Interface) into the CRM. Incidents reported in the CRM would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. MDHHS staff review incidents that are considered priorities as they are reported, such as certain types of deaths (suicide and accidental deaths for example) and injuries (related to the use of restrictive interventions or medication errors for example). The system allows for MDHHS to ensure the PIHP's process for reporting these incidents and events is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would require submission of a corrective action plan by the PIHP. PIHPs have 30 days to respond to remediations generated by priority incidents reported or those requested by MDHHS-BPHASA staff. The CRM allows for MDHHS to monitor for trends, outliers, and issues more closely and in real time. MDHHS will monitor incidents for CWP beneficiaries, establish a baseline “penetration” rate and set targets for reductions in the rate of critical incidents that will result from systems improvement strategies from systems improvement strategies identified in Appendix H and oversight of critical incidents.

OFFICE OF RECIPIENT RIGHTS: On a semi-annual basis, local CMHSP ORRs report to MDHHS the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDHHS include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local Rights office, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semi- annual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population, including CWP beneficiaries. An annual report is produced by the State ORR and submitted to community partners and the Legislature.

Appendix G: Participant Safeguards

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

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

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

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

MDHHS requires that any beneficiary receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict a beneficiary's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a beneficiary in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, as outlined in the MDHHS/PIHP contract. Each rights office established by the Mental Health Code, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS site review team, which reviews agency policy for consistency with State law during annual visits. The site review team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with beneficiaries or staff.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one)*:

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

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

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The Michigan Mental Health Code 330.1726 requires (in part):
- A recipient is entitled to unimpeded, private and uncensored communication with others by mail and telephone and to visit with persons of his or her choice;
- The right of a recipient to communicate by mail or telephone or receive visitors shall not be further limited except as authorized in the person's individual plan of services. The Michigan Mental Health Code 330.1744 requires (in part):
- The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage.
- Any restrictive or intrusive intervention must be identified through the Person-Centered Planning process and must be detailed in the individuals IPOS consistent with the HCBS Final Rule and the HCBS Medicaid Provider Manual chapter. This requirement is not impacted by the development of a Behavior Treatment Plan
• Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan;
• Identify the specific assessed need(s);
• Document the positive interventions and supports used previously;
• Document less intrusive methods that were tried and did not work, including how and why they did not work;
• Include a clear description of the condition that is directly proportionate to the assessed need;
• Include regular collection and review of data to measure the effectiveness of the modification;
• Include established time limits for periodic review of the modification;
• Include informed consent of the individual; and
• Include assurances that the modifications will cause no harm to the individual.
All restrictive or intrusive interventions must be reviewed on a quarterly basis and recorded in a progress note. If the review determines that changes are required, this will be reflected in an amendment to the IPOS.

MDHHS Administrative Rules 330.7199 requires (in part):
-The plan [of services and supports] shall identify, at a minimum, all of the following:
Any restrictions or limitations of the recipient's rights. Such restrictions, limitations or intrusive behavior treatment techniques shall be reviewed and approved by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis. Any restriction or limitation shall be justified, time-limited and clearly documented in the plan of service. Documentation shall be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future.

The MDHHS contract with the PIHPs and CMHSPs includes MDHHS Standards for Behavior Treatment Plan Review Committees, which addresses the use of restraint, seclusion, intrusive and restrictive interventions.

It is the policy of MDHHS that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here in section IV, with beneficiaries served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the beneficiary or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards contained MDHHS/PIHP contract, including those for its appointment, duties, and functions. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. The Committee shall be comprised of at least three individuals, one of whom shall be a board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist as defined in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the beneficiary whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support

Specialist. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms. The Committee shall meet as often as needed. Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. “Expedited” means the plan is reviewed and approved in a short time frame such as 24 or 48 hours. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision-making.

The function of the committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
•Aversive Techniques: Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.
•Physical management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the beneficiary or others at imminent risk of serious physical harm. To ensure the safety of each beneficiary and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.
•Restraint: The use of physical devise to restrict a’s beneficiary’s movement. Restraint does not include the use of a device primarily intended to provide anatomical support
•Seclusion: The temporary placement of a recipient in a room, alone, where egress is prevented by any means

2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.
•Peer-reviewed literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as “significance” and “methodology” to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.
•Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the beneficiary for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the beneficiary or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control a beneficiary’s behavior or restrict the beneficiary’s freedom of movement and is not a standard treatment or dosage for the beneficiary’s condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
•Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the beneficiary’s rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the beneficiary; prohibiting unlimited access to food when that access would be harmful to the beneficiary (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of a beneficiary. Use of restrictive techniques requires the review and approval of the Committee.

3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove

any proposed plan for utilizing intrusive or restrictive techniques.
•Positive behavioral supports: A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the beneficiary or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the beneficiary's condition, or when the beneficiary requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.

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

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

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

On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each beneficiary receiving the intervention, as well as:
1.Dates and numbers of interventions used.
2.The settings (e.g., beneficiary's home or work) where behaviors and interventions occurred
3.Observations about any events, settings, or factors that may have triggered the behavior.
4.Behaviors that initiated the techniques.
5.Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
6.Description of positive behavioral supports used.
7.Behaviors that resulted in termination of the interventions.
8.Length of time of each intervention.
9.Staff development and training and supervisory guidance to reduce the use of these interventions.
10.Review and modification or development, if needed, of the beneficiary's behavior plan.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDHHS review. Physical management permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

The use of physical management would also generate an incident report that is reviewed by the CMHSP ORR. If after investigation by the CMHSP ORR, it is determined that staff used physical management (1)

when there is not an imminent risk of harm to the recipient or others, (2) if the physical management used is not in compliance with the techniques approved by the CMHSP, (3) the physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service, and/or (4) physical management is used when other lesser restrictive measures were possible but not attempted immediately before the use of physical management, the CMHSP ORR will substantiate Abuse Class II Use of Unreasonable Force, against the staff. The Michigan Mental Health Code mandates that disciplinary action for any substantiated abuse or neglect.

ON A QUARTERLY BASIS, THE PIHPS TRACK AND ANALYZE THE USE OF ALL PHYSICAL MANAGEMENT AND INVOLVEMENT OF LAW ENFORCEMENT FOR EMERGENCIES, AND THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES BY EACH BENEFICIARY RECEIVING THE INTERVENTION, this includes unauthorized use of restrictive interventions. THE DATA ON THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES MUST BE EVALUATED BY THE PIHP'S QAPIP OR THE CMHSP'S QIP AND BE AVAILABLE FOR MDHHS REVIEW

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

MDHHS monitors the critical incident reporting through the CIRS. Any death or injury requiring emergency treatment or hospitalization that resulted from the use of physical management would be reported within the timeframes specified in G-1-d.

In addition to monitoring critical incident reporting, MDHHS oversees the activities of the CMHSP Behavior Treatment Plan Review Committees through annual site reviews and more frequent oversight if issues or critical incidents related to the use of restrictive interventions are noted. If critical incidents are reported related to the use of physical management, MDHHS may require the PIHP and CMHSP staff to receive training in positive behavioral supports, as well as recommend other approaches or strategies as appropriate. The data on the use of intrusive and restrictive techniques from CMHSP Behavior Treatment Plan Review Committees must be available for MDHHS review.

The site review team verifies that the process for the Behavior Treatment Plan Review Committees is being implemented per MDHHS policy. If the process is not being implemented per MDHHS policy, this finding will be reflected in the written site review report which would in turn require submission of a corrective action plan by the PIHP/CMHSP.

The MDHHS site review team ensures that any restrictive or intrusive measures in place are supported by an HCBS compliant IPOS.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDHHS review.

Appendix G: Participant Safeguards

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

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

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

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

MDHHS requires that any beneficiary receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict a beneficiary's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, the Medicaid Specialty Supports and Services Program contract between MDHHS and the PIHPs; the Agreement Between MDHHS and CMHSPs For Managed Mental Health Supports and Services.

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

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS site review team, which reviews agency policy for consistency with State law during annual visits. The site review team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with beneficiaries or staff.

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

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

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

Appendix G: Participant Safeguards

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

Most CWP beneficiaries live with family and medication management and administration are the family's responsibility. In those few instances where the beneficiary and family use licensed settings, the PIHPs and their affiliated CMHSPs have ongoing responsibility for "second line" management and monitoring of beneficiary medication regimens ["first line" management and monitoring is the responsibility of the prescribing medical professional]. The beneficiary's individual plan of services and supports must contain complete information about their medications regimen [i.e., what each medication is for; frequency and dosage; signs and symptoms suggesting/requiring attention, etc.]. These details and any other monitoring recommendations from the prescribing professional are shared with the members of the beneficiary's planning team [as authorized by the beneficiary], and all provider staff with medication administration/self-administration assistance/monitoring responsibilities. This helps all within the beneficiary's planning/service/support network to know when to request a formal medication review outside those scheduled within the plan. Case managers' monitoring of beneficiaries includes general monitoring of the effectiveness of the beneficiary's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with beneficiaries, and discussion with direct care and other staff as appropriate.

The PIHP/CMHSP medications monitoring procedure, called a Medication Review, is by definition the evaluation and monitoring of medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications. The frequency of regular medication reviews must be specified in the beneficiary's individual plan of services and supports. The average frequency of Medication Reviews performed for those beneficiaries who required them is approximately once per quarter.

Any use of behavior modifying medications requires specific approval of a Behavior Treatment Plan Review Committee. These requirements are outlined in contracts with the PIHPs and specify committee membership and review requirements are included in G-2-b. Committee reviews of the use of behavior modifying medications must be completed at least quarterly, but may be completed more frequently at the discretion of the committee. Reports from the Committee must be submitted to MDHHS for CWP beneficiaries on a quarterly basis.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the PIHP must follow-up to address the beneficiary's health and welfare as applicable, report through the critical incident reporting system (CIRS) and conduct a sentinel event investigation.

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

In addition to the regular Medication Reviews by the PIHP/CMHSP medical professionals specified in the plan, case managers and others are trained to spot signs and symptoms of potentially harmful practices and can request an unscheduled Medication Review and a planning meeting to address any confirmed issues.

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

During annual MDHHS site reviews of the PIHPs, MDHHS staff on the site review team evaluate residential service provider compliance with staff training and incident reporting requirements, as well as the PIHP's monitoring and follow-up of medication errors. In addition, the site reviews evaluate compliance with Behavior Treatment Plan Committee. If a potentially harmful practice is identified at any level, the PIHP works with the provider to correct the practice. If a residential provider does not cooperate toward correction, the PIHP may file a complaint with MDHHS, and per rule R330.1804: (2) Upon receipt of a complaint regarding the provision of specialized program services, the department shall conduct a review within 30 days to determine whether these rules have been violated. The department shall issue a written report of its findings and provide a copy to the department of human services, the complainant, the facility, and the placing agency; (3) The department shall issue a complaint against a facility if rule violations warrant; (4) Failure of the licensee to fully cooperate with the department in connection with inspections and investigations is a ground for the denial, suspension, or revocation of, or refusing to renew, a facility's certification. Non-cooperation from non-residential providers can result in the PIHP revoking their contracts/removing them from their waiver services provider panel.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

The Michigan Administrative Rule 330.7158 addresses medication administration:
(1) A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
(2) A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
(3) A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
(4) A provider shall review the administration of a psychotropic medication periodically as set forth in the recipients individual plan of service and based upon the recipients clinical status.
(5) If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
(6) A provider shall record the administration of all medication in the recipient's clinical record.
(7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.

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

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

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

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

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

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

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

Providers responsible for medication administration are required to record medication errors as noted in G-3-c.i above in Administrative Rule 330.7158 (7). PIHPs must report certain medication errors to MDHHS per the MDHHS/PIHP and CMHSP contracts.

"Medication errors" mean: wrong medication; wrong dosage; double dosage; or missed dosage which resulted in death or loss of limb or function or the risk thereof. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which beneficiaries have refused medication. Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDHHS-MHSA when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur.

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

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

During these site reviews, MDHHS staff verifies the PIHP's process for Critical Incident Reporting is being implemented per MDHHS policy.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents reported within timeframe as required by MDHHS/PIHP contract. Numerator: Number of critical incidents reported for CWP participants within timeframe as required by MDHHS/PIHP contract. Denominator: all critical incidents reported for CWP participants.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of substantiated abuse and neglect events reported for waiver participants that are remediated. Numerator: Number of substantiated abuse and neglect events reported for waiver participants that are remediated. Denominator: All substantiated abuse and neglect events reported for waiver participants.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
NUMBER AND PERCENT OF ENROLLEES REQUIRING HOSPITALIZATION DUE TO MEDICATION ERROR WHERE CASES WERE REMEDIATED BY CONTINUED TRAINING. NUMERATOR: NUMBER OF ENROLLEES REQUIRING HOSPITALIZATION DUE TO MEDICATION ERRORS. DENOMINATOR: ALL ENROLLEES WITH REPORTED INCIDENTS OF HOSPITALIZATION FOR INJURIES OR MEDICATION ERROR.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who have received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of participants who received information and education in the prior year. Denominator: Number of participants sampled.

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents reported for CWP enrollees where cases were resolved within 90 days. Numerator: Number of critical incidents reported for CWP enrollees. Denominator: All CWP enrollees.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
NUMBER AND PERCENT OF BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT DUE TO MEDICATION ERROR WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS

TYPE. NUMERATOR: NUMBER OF BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT NOT DUE TO MEDICATION ERROR. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF EMERGENCY MEDICAL TREATMENT FOR MEDICATION ERRORS.

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

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of enrollees requiring hospitalization due to injury related to the use of physical management (PM) where remediation was completed. Numerator: Number of enrollees requiring hospitalization due to injury related to the use of PM where remediation was completed. Denominator: Number of enrollees requiring hospitalization due to injury related to the use of PM.

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

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of completed Individual Plans of Service (IPOS) with restrictions identified and are in compliance with HCBS requirements. Numerator: Completed IPOS with restrictions identified that are in compliance with HCBS requirements. Denominator: All completed IPOS with restrictions identified.

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

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

		Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate random sample, 95% confidence interval.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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

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

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

MDHHS will analyze a 100% sample of all reported critical incidents involving CWP beneficiaries from the CIRS, as well as analyze subcategories of critical incidents reported through the CIRS who required hospitalization due to an injury related to use of restrictive intervention or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDHHS is particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effective of preventive strategies.

The PIHPs submit, on a quarterly basis, aggregate data by event category for number of sentinel events and plans of action or interventions which occurred during the three month period. The MDHHS analyzes the data and prepares a report on the number of sentinel events (by category) per thousand persons served who meet the population definition. As with all performance indicators, MDHHS reviews performance, with potential follow-up by contract managers to determine what quality improvement action is taking place; and/or to develop performance objectives aimed at reducing the risk of sentinel events occurring; and/or to impose other sanctions.

MDHHS also has regular meetings with MDHHS and DCWL Licensing staff to identify issues of concern related to people receiving services in licensed settings. Agendas and meeting notes are maintained.

In the IPG Final Report, CMS requested information regarding effectiveness of the prevention policies and procedures for this waiver. As indicated elsewhere in this application, each beneficiary has an IPOS developed based on the beneficiary's assessed needs and strengths. The IPOS also identifies a methodology to be used by staff for addressing identified needs. Safety and crisis plans are also developed for each beneficiary. Required staff training includes training in the IPOS, as well as in Recipient Rights.

b. Methods for Remediation/Fixing Individual Problems

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

If an incident is reported to the PIHP ORR or PIHP, the system described in this Appendix would require the following steps be taken. Any critical incident for a participant has a short-term response to assure the immediate health and welfare of the beneficiary for whom the incident was reported and a longer-term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified. Second, the PIHP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the PIHP ORR, that office begins the process of determining whether there may have been a violation of the beneficiary's rights. If the PIHP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a PIHP must develop and implement either a) a plan of action or intervention (per MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The PIHP ORR also follows its process to investigate and recommend remedial action to the PIHP Director for follow-up.

If an egregious event is reported through the CIRS or through other sources, MDHHS may follow-up through a number of different approaches, including sending a site reviewer or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the PIHP, requiring additional training for PIHP providers, or other strategies as appropriate. During a site visit, if the site review team member identifies an issue that places a beneficiary in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

The MDHHS incorporates all of the programs operated in the public mental health system, including the 1115 Behavioral Health Waiver Demonstration, Habilitation Support Waiver (HSW), Children's Waiver Program (CWP), and the Waiver for Children with Serious Emotional Disturbance (SEDW). The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of fund source. The MDHHS site review team will conduct comprehensive annual reviews at each PIHP (and affiliate CMHSPs).

The site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of §1915(c) waiver beneficiaries are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, beneficiary/community partner meetings and beneficiary interviews. In addition to identifying individual issues that are addressed in remediation, the MDHHS findings are also used for identifying trends to implement systems improvements. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiary.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Behavioral Health Code Charts and Provider Qualifications; review of PIHP policy for Critical Incident Reporting System and verification that the process is being implemented per MDHHS policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDHHS policy; and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code.

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

- Includes services and supports that align with and address all assessed needs
- addresses health and safety risks
- is developed in accordance with MDHHS policy and procedures, including alignment with MDHHS approved CFA&P scenarios and any associated CFA&P implementation plans
- is updated at least annually

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

MDHHS contracted staff conducts beneficiary interviews with a random sample of those beneficiaries whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with beneficiaries who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the waivers.

The findings of each PIHP site review are sent to the PIHP with the requirement that the PIHP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations is reviewed at the next annual PIHP site review to ensure all concerns

have been appropriately addressed. Results of the MDHHS site reviews are shared with MDHHS management team, the Quality Improvement Council (QIC), and AHCBS staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Michigan's QAPIP has been developed with the input of beneficiaries and the Mental Health QIC. Michigan's QAPIP is revised with the 1115 Behavioral Health Waiver Demonstration and reflects the activities, concerns, input or recommendations from the MDHHS's Encounter Data Integrity Team (EDIT), EQR activities and the terms and conditions from CMS' previous waiver approvals. The MDHHS Site Review Protocol is reviewed and revised to address changes in policy resulting from trends or system improvements.

The existing infrastructure in Michigan includes 1115 Behavioral Health Waiver Demonstration to allow Michigan to provide mental health services not otherwise covered under the State Plan through a managed care delivery system. The concurrent 1115 Behavioral Health Waiver Demonstration/1915(c) waivers enables Michigan to use Medicaid managed care program features such as quality improvement performance plans and external quality reviews as important parts of effective monitoring of the CWP.

Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the Quality Assessment and Performance Improvement Programs. These elements were required as part of the AFP (2002) and are now part of the MDHHS/PIHP contracts and they are reviewed by MDHHS staff and/or the EQR process. While a review of the following three areas is not specific to the CWP, it assures overall quality services for all beneficiaries.

EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. MDHHS contracts with Health Services Advisory Group (HSAG) to conduct the EQR. The EQR consists of desk audits of PIHP documents, site visits to PIHPs or both. One EQR component addresses PIHP compliance to BBA requirements. The other two EQR activities involve validation of PIHP performance improvement projects and performance indicators.

The EQR address requirements for customer services: staff who are knowledgeable about referral systems to assist beneficiaries in accessing services, a range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP network, performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP, focus of customer services is customer satisfaction and problem avoidance, assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications, and the relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Appeals and Grievances Mechanisms: The EQR reviews the process, information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record-keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to site review by MDHHS. MDHHS uses its Appeals and Grievances database to track the trends of the types of requests for fair hearing and their resolution, to identify PIHPs that have particularly high volumes of appeals, to identify themes, such as appeals related to a specific service and to address any trends that are noted through training, policy clarification, or other methods. MDHHS also has regular meetings with the Administrative Tribunal to address trends and identify solutions.

Quality Assessment and Performance Improvement Programs: The MDHHS contracts with PIHPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors the PIHP implementation of their local QAPIP plans that must include the required standards. MDHHS site reviews include review of implementation of standards for sentinel events and credentialing of providers. MDHHS collects data for performance indicators and performance improvement projects as described in b.i. below.

In addition to the AHCBS strategies implemented for all beneficiaries, the CWP staff review all applications and monitor the timeliness of recertifications by way of the web-based WSA database. The CWP staff may participate

in MDHHS site reviews of clinical and administrative records or provide technical consultation as requested by the site review team during a PIHP/CMHSP review.

Data from site reviews and consultations has been used for systems improvement activities. Examples include: providing technical assistance to PIHPs and CMHSPs during quarterly webinars; mandating technical assistance for sites with high levels of out-of-compliance; completing additional follow up record reviews to ensure Quality Improvement Project is being implemented; and identifying topics for technical assistance webinars or conferences at both state and local levels to address systemic issues.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: The QIC meets every other month. For the PIHPs/CMHSPs and MDHHS, QI activities are ongoing.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

MDHHS uses performance indicators to measure the performance of the PIHP on a number of domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management. Data collected for performance indicators can be identified at the individual CWP beneficiary level if necessary.

Indicators are used to alert MDHHS of systemic issues and PIHP-specific issues that need to be addressed immediately; to identify trends to watch; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter data located in MDHHS's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDHHS and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action.

Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDHHS website. Results of the performance indicators are shared with MDHHS management team, the QIC and CWP staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

PIHPs are required by contract to submit Medicaid Utilization and Net Cost (MUNC) reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP and can be analyzed at the CWP beneficiary level. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDHHS to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDHHS management team, the EDIT, and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Critical Incidents are reported, reviewed, investigated and acted upon at the local level by each PIHP for all CWP beneficiaries.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDHHS semi-annually. Aggregate data are shared with MDHHS management team and the QIC. Information is used by MDHHS to take contract action as needed, becomes the focus of on-site reviews conducted by MDHHS, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP Offices of Recipient Rights (ORR) report summaries of all allegations received and investigated, identify intervention taken, and the number of allegations substantiated. The summaries are reported by category of rights violations. An annual report is produced by the State ORR and submitted to community partners and the Legislature. Data collection improvements distinguish Medicaid beneficiaries from other beneficiaries that are served.

The MDHHS staff collaborates with the Quality Improvement Council to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and community partner concerns. Michigan requires all PIHP/CMHSPs to conduct a minimum of two performance improvement projects. All PIHP/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDHHS; in the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide. All PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHP/CMHSPs choose their second performance improvement project.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDHHS performance improvement project reports are shared with MDHHS management team, the QIC and CWP staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDHHS staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDHHS site reviews and the EQRs are shared with MDHHS management team and the QIC.

Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Consolidated Reporting:

The MDHHS system improvement strategy encompasses 1915(i) SPA with the following three 1915(c)'s waivers: Children's Waiver program, Habilitation Supports Waiver, and Children with Serious Emotional Disturbances Waiver. MDHHS designed the consolidated quality improvement strategy to assess and improve the quality of services and supports provided through the available the 1915(c) services waiver options and the 1915(i) state plan. This is evident in the following components;
A) beneficiary services-all 1915(c) waivers and the 1915(i) offer similar services to beneficiaries to remain in the community with the focus on the provision of services and supports to maintain or increase a level of functioning in order to achieve a beneficiary's goals of community inclusion and participation, independence, recovery, or productivity.
B) beneficiary safeguards-all 1915(c) waivers and the 1915(i) follow the same beneficiary safeguards outlined throughout the individual waiver and 1915(i) SPA applications.
C) quality management: the information below outlines the approach which is the same or similar across 1915(c) waivers and the 1915(i).

The quality management approach is the same or similar across waivers and the 1915(i):
a) methodology for discovering information: the state draws from several tools to gather data and measure individual and system performance. Tools utilized include the record review protocol, the CHAMPS, web-based database called the Waiver Support Application, and a critical incident reporting system across all waivers and 1915(i) beneficiaries.
b) manner in which individual issues are remedied: MDHHS is the single state agency responsible for establishing the components of the quality improvement strategy which includes the remediation of all waiver and 1915(i) issues at an individual level and all actions and timelines are recorded and tracked through annual monitoring activities.
c) process for identifying and analyzing trends/patterns: data gathered from the record reviews will be used initially to foster improvements and provide technical assistance at the agency whose records are being reviewed. Annually, this data will be compiled to look for systemic trends and areas in need of improvement and published in the state's annual report. Using encounter data, measure penetration rates of beneficiaries who access services at the PIHP level to determine a baseline, median, and negative statistical outliers. The state will track and trend critical incidents that involve beneficiaries at the PIHP level: baseline, then identify negative statistical outliers and track and trend requests for Medicaid fair hearing by beneficiaries, and track and trend by PIHP the fair hearing decisions that are found in favor of the beneficiary.
d) majority of the performance indicators are the same: the majority of the performance measures associated with CMS assurances are the same.

The provider network is the same across the 1915(c) waiver programs and the 1915(i). All provider types (i.e. licensed/non-licensed, certified/non-certified) within the 1915(c) waiver programs and the 1915(i) are required to meet the same training and background check requirements according to policy in order to furnish HCBS.

Provider oversight is the same across the 1915(c) waiver programs and the 1915(i) and all services are included in the consolidated reporting.

Sampling Methodology for Consolidated Reporting:
Pulling a statistically significant sample from the total population of all 1915(c) waivers (HSW, CWP and SEDW) and 1915(i)SPA operated by the MDHHS. This is based on a 5% margin of error, a 95% confidence level, and a response distribution of 50%. The state then stratifies the sample for each specific waiver by drawing at least a minimum number of records for each waiver. The stratification standards the state uses for minimum sampling is 10% margin of error, 95% confidence level, and a response distribution of 50%.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIC would address QI strategies and systems improvements required for the CWP, as well as all the waiver populations served by Michigan's mental health system. The QIC also has a formal opportunity to identify issues at a meeting in anticipation of the annual contract renewal. To the extent that the MDHHS/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract. If the QIC were to identify an issue that would require changes to the contract prior to the expiration of the current contract, the MDHHS could amend the contract. Procedural changes that do not require contract changes can be implemented immediately. Additionally, if issues are identified through trending and analysis, the QIC may make recommendations to MDHHS upper management team to revise the QIS. The final decision on changes to the QIS is made by the MDHHS upper management team.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Children's Waiver operates concurrently with the 1115 Behavioral Health Waiver Demonstration waiver. The CWP capitation payments are made to the PIHPs for the delivery of waiver services and PIHPs in turn, pays within [and when requested, outside] their networks of contracted providers. There are no fee-for-service payments for waiver services.

a) The MDHHS/PIHP contract includes requirements for PIHPs to complete independent audits.

b) Pursuant to the MDHHS/PIHP and MDHHS/CMHSP contracts, PIHPs and CMHSPs must submit to MDHHS a Financial Statement Audit and a Compliance Examination Report conducted in accordance with the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements 10 and the CMH Compliance Examination Guidelines attached to the MDHHS/PIHP and MDHHS/CMHSP contracts.

The annual independent financial audit must clearly indicate the operating results for the reporting period and financial position of the PIHP at the end of the fiscal year. The Financial Statement Audit must be conducted in accordance with Generally Accepted Auditing Standards.

The annual CMHSP Compliance Examination requires that an independent auditor examine compliance issues related to contracts between PIHPs and the MDHHS to manage the concurrent 1115 Behavioral Health Waiver Demonstration and the 1915(c) waiver programs as well as general fund and Mental Health Block Grant funds. PIHPs must assure that compliance issues are monitored by either requiring their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs or require the affiliated CMHSPs to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. The CMH Compliance Examination does not replace or remove any other audit requirements that may exist, such as a financial statement audit and/or a single audit.

The PIHP must submit to MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end.

PIHPs/CMHSPs are obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the State's BBA- compliant Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: If the code is approved under this contract, eligibility of the beneficiary on the date of service, service is included in the beneficiary's Individual Plan of Service (IPOS), the date/time of service, service provided by a qualified practitioner and falls within the scope of the code billed/paid, amount billed does not exceed the payer's (PIHP or CMHSP) contracted amount, and amount paid does not exceed the payer's (PIHP or CMHSP) contracted amount. Verification procedures must utilize statistically sound sampling methodology in accordance with Office of Inspector General (OIG) standards. PIHP methodology must identify and document the sampling methodology used to determine sampling and describe any tools used to assist in the sample determination process. This process identifies potential issues across persons served including the CWP population. Any issues identified in this process would be expected to be included in quarterly Program Integrity Activities reports submitted by PIHPs.

In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend $750,000 or more in federal awards during their fiscal year must submit to MDHHS a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to PIHPs. The 834 process generates an enrollment file based upon the PIHP provider ID number and the beneficiary's assignment to the CWP Managed Care benefit plan. This process uses edits to assure only the PIHPs that have a contract with the State are provided the capitation payment for the CWP. Each PIHP has a unique state-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to a contracted PIHP. This process includes verifying the participant's Medicaid eligibility and CWP benefit plan. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PIHP using the Medicaid Management Information System (MMIS). MDHHS utilizes a six-month retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 process.

The repayment and recoupment processes are for the capture and correction of funds for beneficiaries who enrolled or disenrolled in the PIHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the CWP during a given month when the PIHP did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for beneficiaries who disenrolled from the CWP but the PIHPs received capitation payments due to data lags in the 834 process.

MDHHS has developed a report in the CWP database to monitor participants who are not receiving any CWP services. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's participants.

c) The PIHPs are responsible for having independent audits completed as noted above. At the state level, the MDHHS Office of Audit and BPHASA/BCCHPS staff review the reports, issue management decisions, and follow-up as needed.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percent of capitation payments made to the PIHPs only for waiver participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHPs for waiver participants with active Medicaid. Denominator: Total number of all waiver capitation payments.

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

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

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of encounters submitted to MDHHS with all required data elements. Numerator: Number of encounters submitted to MDHHS with all required data elements. Denominator: Number of all encounters submitted to MDHHS.

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

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

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Number of capitation payments made to PIHPs at the approve rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS.

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

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

☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

MDHHS sends a qualified site review team to each PIHP (which includes 46 CMHSPs) to conduct comprehensive annual site reviews to ensure that Michigan's 1915(c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiaries.

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

b. Methods for Remediation/Fixing Individual Problems

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

MDHHS has developed a report in the CWP database to track and monitor the CWP beneficiaries not receiving CWP services on a quarterly basis. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's beneficiaries. For active CWP beneficiaries not receiving CWP services in three consecutive months, MDHHS CWP staff will provide technical guidance with the PIHP and may recommend disenrollment from the CWP.

MDHHS Office of Audit reviews the Financial Statement Audit and Compliance Examination Reports. The State will issue a management decision on findings, comments, and questioned costs contained in PIHP Financial Statement Audit and Compliance Examination Report. The management decision relating to the Financial Statement Audit will be issued within six months after the receipt of a complete and final reporting package. The management decision relating to the Compliance Examination will be issued within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the finding or comment is sustained; the reasons for the decision, and the expected Contractor action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, the State may request additional information or documentation from the PIHP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs.

Per the MDHHS/PIHP contract, the PIHP must include program integrity compliance provisions and guidelines in all contracts with subcontracted entities/network providers and if program integrity compliance activities are delegated to subcontractors, the subcontract must comply with the requirements outlined in the MDHHS/PIHP contract. This includes submission of quarterly reports detailing program integrity compliance activities, assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity, provisions for routine internal monitoring of program integrity compliance activities, prompt response to potential offenses and implementation of corrective action plans, prompt reporting of fraud, waste, and abuse to PIHP and implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities' employees at all levels. For cases of fraud, waste and abuse where it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

If the MDHHS site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Individual remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by MDHHS. Systemic remediations will be reviewed for effectiveness at the next scheduled PIHP site review.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

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

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

This §1915(c) waiver operates concurrently with the state's 1115 Behavioral Health Waiver Demonstration. Please refer to Michigan's approved 1115 Behavioral Health Waiver Demonstration application and associated materials.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The PIHP contracted providers submit CWP services encounters/claims to the PIHPs; the clean claims are then adjudicated and paid [out of the PIHP's capitation funds] within the payment timeliness parameters specified in their PIHP contracts; the definition of clean claim, the flow of billings, and the payment timeliness parameters, etc. are governed by the MDHHS/PIHP contract.

Current in-scope services for CWP include Community Living Supports and Respite services. For these services, MDHHS has executed a contract for a State sponsored EVV solution that will operate across all applicable waivers and state plan services. The State sponsored EVV solution includes a pre-billing component to ensure that only clean claims can be successfully adjudicated/processed. Claim submissions that do not pass the pre-billing process will result in a notification being sent through the system indicating that the claim requires correction.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one):*

- ( ) ***No. state or local government agencies do not certify expenditures for waiver services.***

◉ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☒ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

a) For this waiver, the PIHP incurs certified public expenditures (and is a CMHSP, which is a local government agency).
b) The PIHPs collect and calculate actual cost data and attest to the fact that the data reporting is accurate. Costs are reported through various financial documents both throughout the fiscal year and at the close of the fiscal year and are subject to annual auditing to assure that the CPE is based on total computable costs for the concurrent 1115 Behavioral Health Waiver Demonstration/1915(c) waiver.
c) Expenditures are based on eligibility, reporting of encounters for the provision of valid waiver services and the cost for providing those services. CHAMPS verifies eligibility and checks for encounters. Annual audit compliance exams are used to verify that the CPE are properly identified, categorized, distributed, and reported by fund source are eligible for FFP. MDHHS reviews the annual compliance exam to assure that any irregularities are addressed by the PIHP.

Appendix I: Financial Accountability

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

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The quarterly CMS 64 Claims for federal financial participation for this waiver program are made based on the monthly §1915(c) waiver capitation payments made to the PIHPs on behalf of the participants enrolled in this waiver program.

a) These capitation payments are made only after each beneficiary's active Medicaid eligibility has been verified through CHAMPS. Per the performance measure in the QIS for this appendix, a representative random sample of all CWP participants is reviewed to assure that capitation payments are made only for CWP participants with active Medicaid eligibility.

b) The site review team reviews a proportionate random sample of CWP participants during each comprehensive full review. This review includes an examination of the participant's IPOS and the supporting documentation (e.g., progress notes, time sheets, claims from providers to the PIHP, or any other relevant evidence) that the services were delivered that were appropriate to the participant's identified needs in the amount, scope, duration and frequency specified in the IPOS. This is reflected in a performance measure in the QIS for Appendix D.

c) MDHHS developed a report in the CWP database to track and monitor the CWP beneficiaries not receiving CWP services on a quarterly basis. Report will look at CWP encounters submitted by the PIHP. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's beneficiaries. For active CWP beneficiaries not receiving CWP services in three consecutive months, MDHHS will provide phone consultations with the PIHP and may recommend disenrollment from the CWP.

The MDHHS/PIHP contract specifies the Claims Management requirements incumbent upon the PIHPs and the providers within their networks. It is the encounter and cost data governed by these claims management requirements that constitutes the data basis from which the State's actuary develops the capitation rates for this waiver program's participants.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

As noted in I-1, the CWP database is the system of record for enrollment into the waiver. On a monthly basis, enrollment data and associated payment elements, such as the residential living arrangement, are interfaced from the CWP database to CHAMPS. If the CWP participant is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the CWP benefit plan is opened. If the CWP beneficiary is non-Medicaid eligible, notification is sent back to the CWP database advising that a particular record did not process for payment and must be resubmitted next cycle. If the CWP benefit plan is open, the PIHP receives an electronic member file containing CWP enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the CWP beneficiary has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the CWP capitation payments are made by MDHHS to the PIHPs' accounts and a payment record is issued to the PIHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The PIHPs receive capitation payments and furnish, either directly or through contracts with networks of qualified providers which includes the CMHSPs (who are local governmental entities), the full array of this waiver's services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ◉ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the 1115 Behavioral Health Waiver Demonstration/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the 1115 Behavioral Health Waiver Demonstration/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ◉ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Section 428 of the current year Appropriation Act states: Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

a) County governments have the authority to levy taxes. CMHSPs may receive county appropriations or other revenues described below.

b) Per the MDHHS/CMHSP contract, the sources of other revenue are described in Section 7.0 Contract Financing. The revenue sources include county appropriations, other appropriations and service revenues, gifts and contributions, special fund account, investment interest, and other revenues for mental health.

c) The mechanism used to transfer funds to the Medicaid Agency is an intergovernmental transfer, specifically, the PIHP shall provide to MDHHS on a quarterly basis the PIHP obligation for local funds as a bon fide source of match for Medicaid.

☒ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by local government agencies as CPEs, as specified in Item I-2-c:

Not applicable

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The requirement to exclude room and board costs from Medicaid payments is stated in the Michigan Medicaid Provider Manual, as well as within the MDHHS Contract with the PIHPs. The PIHPs pay for CWP services. The other costs of the subcontractor residential provider, including room and board, can only be paid by using SSI or state general fund dollars.

Appendix I: Financial Accountability

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

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

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs***

attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

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

Appendix I: Financial Accountability

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

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

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

i. Co-Pay Arrangement.

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

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

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (◉) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- (○) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*32155.18*	*15196.00*	*47351.18*	*81108.00*	*4631.00*	*85739.00*	*38387.82*
2	*34936.53*	*16566.00*	*51502.53*	*83136.00*	*4747.00*	*87883.00*	*36380.47*
3	*36336.77*	*17229.00*	*53565.77*	*85214.00*	*4865.00*	*90079.00*	*36513.23*
4	*37888.90*	*17973.00*	*55861.90*	*87344.00*	*4987.00*	*92331.00*	*36469.10*
5	*39305.35*	*18635.00*	*57940.35*	*89528.00*	*5112.00*	*94640.00*	*36699.65*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 1	*669*	*669*
Year 2	*669*	*669*
Year 3	*669*	*669*
Year 4	*669*	*669*
Year 5	*669*	*669*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The ALOS has been projected based on actual experience from recent historical experience, reflecting year-over-year increases during the new 5-year waiver period based on projected phase-in and phase-out assumptions. The calculation of the ALOS estimate for WY 1 in the renewal period is equal to the projected total number of days for members on the waiver during WY 1 divided by the unduplicated participant count. The ALOS is calculated based on actual experience through December 2023 and estimated phase-in and phase-out assumptions for future time periods. Changes in ALOS over the course of the 5-year renewal period are based on projected changes in enrollees over the waiver period and reflect slightly shorter stays if more people phase into the waiver than phase out in a given year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

We have updated the base utilization and cost per unit experience from the previously filed and approved waiver amendment to reflect SFY 2022 experience. Unless otherwise stated, Factor D for the new 5-year waiver period for the renewal (October 1, 2024 through September 30, 2029) was projected from SFY 2022 of the current period data in the following manner:

- *Base number of users was calculated by determining the allocated number of users from the historical experience. The percentage of members identified as using a service from the historical unduplicated participant count was applied to future projected unduplicated participant counts to determine the number of users across the 5-year renewal period. Therefore, a projected number of users for WY 1 represents projected experience for SFY 2024 multiplied by the change in unduplicated participant count from SFY 2024 to WY 1. Growth from WY 1 to WY 5 of the renewal period applied the same methodology.*
- *Baseline average units per user was calculated by adjusting the historical experience of average units per user by projected growth in the ALOS. Therefore, a projected average units per user was developed by taking actual experience and multiplying by the change in ALOS to projected future time periods. The change reflected in WY 1 of the renewal period for average units per user was calculated from the projected SFY 2024 average units per user multiplied by the estimated change in ALOS.*
- *Baseline average cost per unit values were calculated by adjusting the historical experience of unit cost in SFY 2022. Using the total expenditures by waiver service developed from the allocation process and dividing by the total number of units, the cost per unit was established for most of the services. Factor D average cost per unit was trended at a rate of 4.0% per year and select services were further adjusted to account for additional adjustments to account for the increase in direct care worker (DCW) cost increase. The cost per unit values were increased for health maintenance organization costs of 5.0% of the total adjusted cost per unit.*

Factor D development for the services listed below are exceptions to the methodology outlined above.

- *Enhanced Transportation: Removed from the CWP service array; utilization so limited resulted in immaterial impact to Factor D*
- *Equine Therapy: Added to Activity Therapy as a Specialty Service*
  - *Number of Users – We estimate the number of unduplicated annual users of Activity Therapy to increase by 5% (9 users)*
  - *Avg. Units Per User – We are assuming the average baseline units (sessions) per user to be 27, consistent with Activity Therapy*
  - *Avg. Cost/Unit – Average cost per unit was estimated at $80 and informed by fee schedule assumptions in other states*
- *Overnight Health and Safety Support - Revisions to eligibility language*
  - *Number of Users – We estimate the number of unduplicated annual users to be 20% of unduplicated participants in the waiver (134 in SFY 2025)*

Transportation activity costs will continue to be included in the rates for those specific waiver services which are identified in each waiver application renewal. Michigan is conducting work outside of the waiver renewal related to the allocation of the costs for non-emergency medical transportation (NEMT) that are currently included in waiver services. Transportation costs are not currently reported separately for waiver services therefore cannot be itemized separately in the J tables. Assessments are a separate service and provided through our State Plan, therefore would not be itemized separately in the J tables.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

We have updated the base experience for the Factor D' expenditures from the previously filed and approved waiver amendment to reflect SFY 2022 experience. Factor D' was trended at a rate of 4.0% per year.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

We have updated the Factor G and G' expenditures for Waiver Years 1 through 5 to be based on the Louisiana ICF/IID waiver application for children age 0-20 (LA.0361.R04.15) Factor G and G' costs. This program is similar to Michigan's CWP program.

Factor G was trended at a rate of 2.5% per year and Factor G' was trended at a rate of 2.5% per year. The trend rate for D and D' are higher than G and G' given Michigan's historical direct care worker trends have been higher than the national average.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

We have updated the Factor G and G' expenditures for Waiver Years 1 through 5 to be based on the Louisiana ICF/IID waiver application for children age 0-20 (LA.0361.R04.15) Factor G and G' costs. This program is similar to Michigan's CWP program.

Factor G was trended at a rate of 2.5% per year and Factor G' was trended at a rate of 2.5% per year. The trend rate for D and D' are higher than G and G' given Michigan's historical direct care worker trends have been higher than the national average.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Respite	
Financial Management Services	
Community Living Supports	
Environmental Accessibility Adaptations	
Home Care Training, Family	
Home Care Training, Non-Family	
Overnight Health and Safety Support	
Specialized Medical Equipment & Supplies	
Therapeutic Activities	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**4322943.03**
Respite care service - 15 minutes	☒	15 minutes	463	1211.00	7.71	**4322943.03**	
Financial Management Services Total:							**545487.39**
Financial Management Services	☒	Per month	409	9.00	148.19	**545487.39**	
Community Living Supports Total:							**12516456.15**
CLS, Unlicensed	☒	15 minutes	477	3135.00	8.37	**12516456.15**	
Environmental Accessibility Adaptations Total:							**232016.40**
Home Modifications per service	☒	Service	14	1.00	16572.60	**232016.40**	
Home Care Training, Family Total:							**127396.08**
Home Care Training, Family	☒	Encounter	157	4.00	202.86	**127396.08**	
Home Care Training, Non-Family Total:							**72453.12**
Home Care Training, Non-Family	☒	Encounter	106	4.00	170.88	**72453.12**	
Overnight Health and Safety Support Total:							**2908775.52**
Overnight Health and Safety Support	☒	15 Minutes	134	4088.00	5.31	**2908775.52**	
Specialized Medical Equipment & Supplies Total:							**131540.02**
Specialized supply (NOS)	☒	Item	1	4.00	158.52	**634.08**	
Durable medical equipment (DME), misc.	☒	Item	36	3.00	1123.87	**121377.96**	
Personal care item	☒	Item				**7841.02**	

GRAND TOTAL:	**21511813.60**
Total: Services included in capitation:	21511813.60
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**32155.18**
Services included in capitation:	32155.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(NOS)			322	811.70	0.03		
Specialized medical equipment (NOS)	☒	ITem	1	2.00	843.48	1686.96	
Therapeutic Activities Total:							512234.40
Activity Therapy - Art, Music, Recreation, Equine	☒	Encounter	189	27.00	93.24	475803.72	
Massage Therapy	☒	15 minutes	39	44.00	21.23	36430.68	
Vehicle Modifications Total:							142511.49
Vehicle Modifications	☒	Item	9	1.00	15834.61	142511.49	

GRAND TOTAL:	**21511813.60**
Total: Services included in capitation:	21511813.60
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**32155.18**
Services included in capitation:	32155.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							4712126.94
Respite care service - 15 minutes	☒	15 minutes	463	1269.00	8.02	4712126.94	
Financial							567315.72

GRAND TOTAL:	**23372538.07**
Total: Services included in capitation:	23372538.07
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**34936.53**
Services included in capitation:	34936.53
Services not included in capitation:	
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management Services Total:							
Financial Management Services	☒	month	409	9.00	154.12	**567315.72**	
Community Living Supports Total:							**13636571.40**
CLS, Unlicensed	☒	15 minutes	477	3286.00	8.70	**13636571.40**	
Environmental Accessibility Adaptations Total:							**241297.00**
Home Modifications per service	☒	Service	14	1.00	17235.50	**241297.00**	
Home Care Training, Family Total:							**132489.16**
Home Care Training, Family	☒	Encounter	157	4.00	210.97	**132489.16**	
Home Care Training, Non-Family Total:							**75353.28**
Home Care Training, Non-Family	☒	Encounter	106	4.00	177.72	**75353.28**	
Overnight Health and Safety Support Total:							**3169528.80**
Overnight Health and Safety Support	☒	15 minutes	134	4285.00	5.52	**3169528.80**	
Specialized Medical Equipment & Supplies Total:							**136867.10**
Specialized supply (NOS)	☒	Item	1	4.00	164.86	**659.44**	
Durable medical equipment (DME), misc.	☒	Item	36	3.00	1168.82	**126232.56**	
Personal care item (NOS)	☒	Item	322	851.00	0.03	**8220.66**	
Specialized medical equipment (NOS)	☒	Item	1	2.00	877.22	**1754.44**	

GRAND TOTAL:		**23372538.07**
Total: Services included in capitation:		23372538.07
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**669**
Factor D (Divide total by number of participants):		**34936.53**
Services included in capitation:		34936.53
Services not included in capitation:		
Average Length of Stay on the Waiver:	326	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Activities Total:							**552776.76**
Activity Therapy - Art, Music, Recreation, Equine	☒	Encounter	189	28.00	96.97	**513165.24**	
Massage Therapy	☒	15 minutes	39	46.00	22.08	**39611.52**	
Vehicle Modifications Total:							**148211.91**
Vehicle Modifications	☒	Item	9	1.00	16467.99	**148211.91**	

GRAND TOTAL:	**23372538.07**
Total: Services included in capitation:	23372538.07
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**34936.53**
Services included in capitation:	34936.53
Services not included in capitation:	
Average Length of Stay on the Waiver:	326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(7 of 9)*

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**4900141.98**
Respite care service - 15 minutes	☒	15 minutes	463	1269.00	8.34	**4900141.98**	
Financial Management Services Total:							**589990.68**
Financial Management Services	☒	month	409	9.00	160.28	**589990.68**	

GRAND TOTAL:	**24309300.11**
Total: Services included in capitation:	24309300.11
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**36336.77**
Services included in capitation:	36336.77
Services not included in capitation:	
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Supports Total:							**14185169.10**
CLS, Unlicensed	☒	15 Minutes	477	3286.00	9.05	**14185169.10**	
Environmental Accessibility Adaptations Total:							**250948.88**
Home Modifications per service	☒	Service	14	1.00	17924.92	**250948.88**	
Home Care Training, Family Total:							**137789.48**
Home Care Training, Family	☒	Encounter	157	4.00	219.41	**137789.48**	
Home Care Training, Non-Family Total:							**78367.92**
Home Care Training, Non-Family	☒	Encounter	106	4.00	184.83	**78367.92**	
Overnight Health and Safety Support Total:							**3295850.60**
Overnight Health and Safety Support	☒	15 minutes	134	4285.00	5.74	**3295850.60**	
Specialized Medical Equipment & Supplies Total:							**142012.64**
Specialized supply (NOS)	☒	Item	1	4.00	171.45	**685.80**	
Durable medical equipment (DME), misc.	☒	Item	36	3.00	1215.57	**131281.56**	
Personal care item (NOS)	☒	Item	322	851.00	0.03	**8220.66**	
Specialized medical equipment (NOS)	☒	Item	1	2.00	912.31	**1824.62**	
Therapeutic Activities Total:							**574888.44**
Activity Therapy - Art, Music, Recreation,	☒	Encounter	189	28.00	100.85	**533698.20**	

GRAND TOTAL:	**24309300.11**
Total: Services included in capitation:	24309300.11
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**36336.77**
Services included in capitation:	36336.77
Services not included in capitation:	
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equine							
Massage Therapy	☒	15 minutes	39	46.00	22.96	41190.24	
Vehicle Modifications Total:							154140.39
Vehicle Modifications	☒	Item	9	1.00	17126.71	154140.39	

GRAND TOTAL:	24309300.11
Total: Services included in capitation:	24309300.11
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	669
Factor D (Divide total by number of participants):	36336.77
Services included in capitation:	36336.77
Services not included in capitation:	
Average Length of Stay on the Waiver:	326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							5110089.33
Respite care service - 15 minutes	☒	15 minutes	463	1273.00	8.67	5110089.33	
Financial Management Services Total:							613585.89
Financial Management Services	☒	month	409	9.00	166.69	613585.89	
Community Living Supports Total:							14794326.72
CLS, Unlicensed	☒	15 minutes	477	3296.00	9.41	14794326.72	
Environmental							260986.88

GRAND TOTAL:	25347672.16
Total: Services included in capitation:	25347672.16
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	669
Factor D (Divide total by number of participants):	37888.90
Services included in capitation:	37888.90
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations Total:							
Home Modifications per service	☒	Service	14	1.00	18641.92	**260986.88**	
Home Care Training, Family Total:							**143303.32**
Home Care Training, Family	☒	Encounter	157	4.00	228.19	**143303.32**	
Home Care Training, Non-Family Total:							**81501.28**
Home Care Training, Non-Family	☒	Encounter	106	4.00	192.22	**81501.28**	
Overnight Health and Safety Support Total:							**3438314.04**
Overnight Health and Safety Support	☒	15 minutes	134	4298.00	5.97	**3438314.04**	
Specialized Medical Equipment & Supplies Total:							**147393.00**
Specialized supply (NOS)	☒	Item	1	4.00	178.31	**713.24**	
Durable medical equipment (DME), misc.	☒	Item	36	3.00	1264.19	**136532.52**	
Personal care item (NOS)	☒	Item	322	854.00	0.03	**8249.64**	
Specialized medical equipment (NOS)	☒	Item	1	2.00	948.80	**1897.60**	
Therapeutic Activities Total:							**597865.68**
Activity Therapy - Art, Music, Recreation, Equine	☒	Encounter	189	28.00	104.88	**555024.96**	
Massage Therapy	☒	15 minutes	39	46.00	23.88	**42840.72**	
Vehicle Modifications Total:							**160306.02**

GRAND TOTAL:	**25347672.16**
Total: Services included in capitation:	25347672.16
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**37888.90**
Services included in capitation:	37888.90
Services not included in capitation:	
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	☒	Item	9	1.00	17811.78	160306.02	
					GRAND TOTAL:		25347672.16
					Total: Services included in capitation:		25347672.16
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		669
					Factor D (Divide total by number of participants):		37888.90
					Services included in capitation:		37888.90
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		327

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							5299673.94
Respite care service - 15 minutes	☒	15 minutes	463	1269.00	9.02	5299673.94	
Financial Management Services Total:							638138.16
Financial Management Services	☒	month	409	9.00	173.36	638138.16	
Community Living Supports Total:							15345061.38
CLS, Unlicensed	☒	15 minutes	477	3286.00	9.79	15345061.38	
Environmental Accessibility Adaptations Total:							271426.40
Home Modifications per service	☒	Service	14	1.00	19387.60	271426.40	
					GRAND TOTAL:		26295281.15
					Total: Services included in capitation:		26295281.15
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		669
					Factor D (Divide total by number of participants):		39305.35
					Services included in capitation:		39305.35
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Care Training, Family Total:							**149036.96**
Home Care Training, Family	☒	Encounter	157	4.00	237.32	**149036.96**	
Home Care Training, Non-Family Total:							**84761.84**
Home Care Training, Non-Family	☒	Encounter	106	4.00	199.91	**84761.84**	
Overnight Health and Safety Support Total:							**3565719.90**
Overnight Health and Safety Support	☒	15 minutes	134	4285.00	6.21	**3565719.90**	
Specialized Medical Equipment & Supplies Total:							**152930.00**
Specialized supply (NOS)	☒	Item	1	4.00	185.44	**741.76**	
Durable medical equipment (DME), misc.	☒	Item	36	3.00	1314.76	**141994.08**	
Personal care item (NOS)	☒	Item	322	851.00	0.03	**8220.66**	
Specialized medical equipment (NOS)	☒	Item	1	2.00	986.75	**1973.50**	
Therapeutic Activities Total:							**621814.32**
Activity Therapy - Art, Music, Recreation, Equine	☒	Encounter	189	28.00	109.08	**577251.36**	
Massage Therapy	☒	15 minutes	39	46.00	24.84	**44562.96**	
Vehicle Modifications Total:							**166718.25**
Vehicle Modifications	☒	Item	9	1.00	18524.25	**166718.25**	

GRAND TOTAL:	**26295281.15**
Total: Services included in capitation:	26295281.15
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**669**
Factor D (Divide total by number of participants):	**39305.35**
Services included in capitation:	39305.35
Services not included in capitation:	
Average Length of Stay on the Waiver:	326