



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

April 2010

<NAME>
<TITLE>
<ADDRESS>
<ADDRESS>
<CITY> <STATE> <ZIP CODE>

Dear Tribal Chair and Health Director:

RE: Notice of Intent to submit the Renewal Application for Michigan's 1915(c) Habilitation Supports Waiver (HSW).

The Michigan Department of Community Health (MDCH) is notifying you of its intent to submit the Section 1915(c) renewal application for the HSW to the Centers for Medicare and Medicaid Services (CMS). If approved, this waiver will allow the State to continue to provide Medicaid funded home and community-based services to Medicaid beneficiaries who have developmental disabilities and who would otherwise require the level of services provided by an Intermediate Care Facility for the Mentally Retarded. Services are provided through the 18 Prepaid Inpatient Health Plans, affiliate local Community Mental Health Service Programs where applicable, and their contracted agencies.

The enclosed document is the waiver as approved by CMS. The HSW will be requesting to combine Chore Services with Community Living Supports. This will not result in any changes to services available and only impacts how the service would be reported. The HSW will also be including self-directed services in the waiver with this application so individuals can use arrangements that support self-determination. Individuals will have the opportunity to control their individual budgets for their services and supports, to direct-hire employees and/or directly contract with providers of their choosing. All other essential features of the waiver will remain as currently approved.

You may submit comments regarding this renewal application to msapolicy@michigan.gov. If you would like to discuss the renewal application, please contact Mary Anne Tribble, Medicaid Liaison for Michigan Tribes. Mary Anne can be reached at (517) 241-7185 or via e-mail at tribblema@michigan.gov.

There is no public hearing scheduled for this waiver renewal application.

Sincerely,

Stephen Fitton, Director
Medical Services Administration

cc: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Sharon Teeple, Inter-Tribal Council of Michigan
Mary Anne Tribble, MDCH

Enclosure

Numbered Letter L 10-17 - Distribution

Mr. Jeffrey D Parker, President, Bay Mills Indian Community
Mr. Derek J Bailey, Tribal Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Mr. W Chris Swartz, President, Keweenaw Bay Indian Community
Mr. Jim Williams, Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. DK Sprague, Tribal Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Mr. Ken Harrington, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Mr. Homer Mandoka, Vice Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Mr. Matt Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Dennis V Kequom Sr, Tribal Chief, Saginaw Chippewa Indian Tribe
Mr. Darwin McCoy, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Ms. Laurel Keenan, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Vacant, Health Director, Grand Traverse Band Ottawa/Chippewa
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Jon Gardner, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Ms. Terry Fox, Health Director, Lac Vieux Desert Band
Ms. Phyllis Davis, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Janice Grant, Health Director, Little River Band of Ottawa Indians
Ms. Sharon Sierzputowski, Health Director, Little Traverse Bay Band of Odawa
Ms. Gail George, Health Director, Nimkee Memorial Wellness Center
Mr. Arthur Culpepper, Health Director, Pokagon Potawatomi Health Services
Ms. Bonnie Culfa, Health Director, Sault Ste. Marie HHS

cc:

Ms. Sharon Teeple, Executive Director, Inter-Tribal Council of Michigan
Mr. Rick Haverkate, Health Service Director, Inter-Tribal Council of Michigan, Inc.
Ms. Jerilyn Church, Director, Detroit American Indian Health Center
Ms. Pamela Carson, , Centers for Medicare and Medicaid Services
Dr. Kathleen Annette, MD, Area Director, Indian Health Service - Bemidji Area Office

**1915 (c) WAIVER APPLICATION
MICHIGAN HABILITATION AND SUPPORTS WAIVER**

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SECTION 1915 (c) WAIVER FORMAT

1. The State of MICHIGAN requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. _____ Yes b. X No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. _____ 3 years (initial waiver)

b. X 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. _____ Nursing facility (NF)

b. X Intermediate care facility for mentally
retarded or persons with related conditions
(ICF/MR)

c. _____ Hospital

d. NF (served in hospital)

e. ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver

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services:

- a. _____ aged (age 65 and older)
- b. _____ disabled
- c. _____ aged and disabled
- d. _____ mentally retarded
- e. X developmentally disabled
- f. _____ mentally retarded and developmentally disabled
- g. _____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. _____ Waiver services are limited to the following age groups (specify):

b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process

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mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. ☒ Other criteria. (Specify): In those instances where the State's enrollment protocol requires the triage of qualified enrollee candidates, first priority will be given to individuals exiting the state's ICF/MR [Mt. Pleasant Center] and then to children ``aging off'' the Children's Waiver [an approved 1915(c) waiver - Control # 4119.92R2.01].

e. ☐ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a. ☒ Yes

b. ☐ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a. ☐ Yes

b. ☒ No

c. ☐ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ☐ Yes

b. ☒ No

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9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. _____ Yes

b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. X Case management (X Supports Coordination')

b. _____ Homemaker

c. _____ Home health aide services

d. _____ Personal care services

e. X Respite care

f. Adult day health

g. X Habilitation

Residential habilitation

 X Day habilitation ('`Out-Of-Home Non-Voc
Habilitation'')

X	Prevocational services
---	------------------------

X _____ Supported employment services

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_____ Educational services

- h. X Environmental accessibility adaptations
 (**``Environmental Modifications``**)
- i. _____ Skilled nursing
- j. _____ Transportation
- k. X Specialized medical equipment and supplies
 (**``Enhanced Medical Equipment & Supplies``**)
- l. X Chore services
- m. X Personal Emergency Response Systems
- n. _____ Companion services
- o. X Private duty nursing
- p. X Family training
- q. _____ Attendant care
- r. _____ Adult Residential Care
- _____ Adult foster care
- _____ Assisted living
- s. _____ Extended State plan services (Check all that
 apply):
- _____ Physician services
- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- X Prescribed drugs (**``Enhanced Pharmacy``**)
- _____ Other (specify): ~~``Enhanced Dental``~~ **
end coverage - no state plan to
enhance**

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t. X Other services (specify): **''Community
Living Supports''**

u. The following services will be provided to
individuals with chronic mental illness:

 Day treatment/Partial hospitalization

 Psychosocial rehabilitation

 Clinic services (whether or not
furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

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- a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
- b. Meals furnished as part of a program of adult day health services.
- c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these

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requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the

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waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. X No

18. The State assures that it will have in place a formal system

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by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of October 1, 2005 is requested.
19. The State contact person for this request is Debra Ziegler, who can be reached by telephone at (517)241-3044 or at zieglerd@michigan.gov.

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20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: **(Note: signature on file
with the waiver application submitted
6/30/2005)**

Print Name: Paul Reinhart

Title: Deputy Director, Medical Services
Administration

Date:

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. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

prepared by mary clarkson 64650
date: 03-27-95
disk: streamline; hcbs95
opus-3

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APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

- _____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.
- _____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- X The waiver will be operated by the Michigan Department of Community Health (MDCH), ~~a separate division within the Single State agency.~~ The Medicaid agency MDCH exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver.
- ~~A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.~~ Within MDCH, the Mental Health & Substance Abuse Services Administration has primary responsibility for the waiver. Operational and administrative functions are delegated to the Prepaid Inpatient Health Plans (PIHPs), local/regional non-state public agencies that provide services through an Agreement with MDCH to perform waiver functions. PIHPs are comprised of one or more Community Mental Health Services Programs (CMHSPs). Functions performed by the PIHPs at the local/regional level include: disseminating information concerning the waiver to potential enrollees, assisting individuals in waiver enrollment, monitoring waiver expenditures against approved levels, conducting level of care evaluation activities, performing prior authorization of waiver

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services, conducting utilization management functions, and recruiting providers. MDCH functions include: managing waiver enrollments against approved limits, reviewing participant service plans to ensure that waiver requirements are met, determining waiver payment amounts, and conducting training and technical assistance concerning waiver requirements. MDCH completes site reviews through the Division of Quality Management & Planning to assess the performance of PIHPs to ensure they perform assigned waiver operational and administrative functions in accordance with waiver requirements.

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APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. X Case Management (**Supports Coordination**)

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. _____ Yes 2. _____ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. _____ Yes 2. _____ No

- X Other Service Definition (Specify): "**Supports Coordination**: Functions performed by a supports coordinator, coordinator assistant, or supports broker that include assessing the need for support and service coordination, and assurance of the following:
- a. Planning and/or facilitating planning using person-centered principles
 - b. Developing an individual plan of service using the person-centered planning process

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- c. Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Habilitation Supports Waiver, other mental health services and community services/supports.
- d. Brokering of providers of services/supports
- e. Assistance with access to entitlements, and/or legal representation
- f. Coordination with the Medicaid Health plan, Medicaid fee-for-service, or other health care providers.

Additionally, the Supports Coordinator shall coordinate with the QMRP on the process of evaluation and reevaluation of recipient level of care (i.e., supply status and update information, summarize input from supports providers, planning committee members, etc.).

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant.

The participant may select an independent supports broker to serve as personal agent and perform supports coordination functions. The primary roles are to assist the participant in making informed decisions about what will work best for him/her, are consistent with his/her needs and reflect the individual's circumstances. The supports broker helps the participant explore the availability of community services and supports, housing, and employment and then, makes the necessary arrangement to link the participant with those supports. Supports brokerage services offer practical skills training to enable individuals to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem-solving.

Whenever independent supports brokers perform any of the supports coordination functions, it is expected that the participant will also have a supports coordinator or supports coordinator assistant employed by the PIHP or its provider network that assures that the other functions above are in place, and that the functions assigned to the supports broker are being performed. The individual plan of service must clearly identify which functions are the responsibility of the supports coordinator, the supports

coordinator assistant and the supports broker. The independent supports broker must work under supervision of a qualified supports coordinator.

The PIHP must assure that it is not paying for the supports coordinator or supports coordinator assistant and the supports broker to perform the same function. Likewise, when a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any supports broker who also attends. During its annual on-site visits, MDCH will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a supports broker are assigned supports coordination responsibilities in a participant's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. The support coordinator or supports coordinator assistant or supports broker will work closely with the participant to assure his/her ongoing satisfaction with the process and outcomes of the supports and services, and available resources.

Supports coordination is reported only as a face-to-face contact with the participant, however the function includes not only the face-to-face contact but also related activities that assure:

- The desires and needs of the participant are determined
- The supports and services desired and needed by the participant are identified and implemented
- Persons chosen by the participant are involved in the planning process
- Housing and employment issues* are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available

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- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the participant, are monitored
- Income/benefits are maximized
- Information is provided to assure that the participant (and their representatives, if applicable) are informed about self-determination
- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning and as specified in appendices D & E of this request.

(*) Support coordination does not include any activities billable as Out-or-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or Community Living Supports.

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages, and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's plan. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

b. _____ Homemaker:

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the

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home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

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1. Services provided by family members
(Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached.
(Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

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- _____ A registered nurse, licensed to practice nursing in the State.
- _____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.
- _____ Case managers
- _____ Other (Specify):

3. Frequency or intensity of supervision
(Check one):

- _____ As indicated in the plan of care
- _____ Other (Specify):

4. Relationship to State plan services
(Check one):

- _____ Personal care services are not provided under the approved State plan.
- _____ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.
- _____ Personal care services under the State plan differ in service definition or provider

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type from the services to be
offered under the waiver.

_____ Other service definition (Specify):

e. X Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

 X Other service definition (Specify):
Services provided to participants whose primary caregivers typically are the same people day after day (e.g., family members and/or adult family foster care providers), and is provided on a short-term, intermittent basis during those portions of the day when the caregivers are not being paid to provide care due to their absence or need for relief. Intermittent means the respite service is not happening regularly or continuously; the service stops and starts repeatedly or with periods in between. Short-term means the respite service is provided during a limited period of time, such as a few hours at a time or for a few days once a year for a vacation. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services, such as for an unpaid caregiver to work full-time. Decisions about the methods and amounts of respite are decided during the person-centered planning process. These services do not supplant or substitute for community living support or other services of paid support/training staff and may not be provided in day program settings.

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Respite care may not be provided by a parent of a minor participant receiving the service, the spouse of the participant, the participant's legal guardian, or the unpaid primary caregiver.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

- ☒ Individual's home or place of residence
- ☒ Foster home
- ☐ Medicaid certified Hospital
- ☐ Medicaid certified NF
- ☐ Medicaid certified ICF/MR
- ☒ Group home
- ☒ Licensed respite care facility
- ☒ Other community care residential facility approved by the State that is not a private residence (Specify type):
- ☒ Home of a friend or relative (not the legal guardian) chosen by the participant; licensed camp; in community settings with a respite worker trained, if needed, by the participant or family. These sites are approved by the participant and identified in the IPOS.

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_____ Other service definition (Specify):

f. _____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. _____ Yes 2. _____ No

_____ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. _____ X _____ Habilitation:

_____ X _____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills

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necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

_____ **X** Day habilitation(**``Out-of-Home Non-Vocational Habilitation``**) Assistance with acquisition, retention, or improvement in self-

help, socialization and adaptive skills and the support services incidental to the provision of that assistance which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day Out-of-Home Non-Vocational habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

 X

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as ~~compliance~~, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a

transitional sheltered workshop
within one year (excluding
supported employment programs).

~~Prevocational services are
available only to individuals who
have previously been discharged
from a SNF, ICF, NF or ICF/MR.
[struck per State Medicaid Manual
4442.3(B)(3)]~~

Check one:

- _____ Individuals will not be
compensated for
prevocational services.
- X When compensated,
individuals are paid at
less than 50 percent of
the minimum wage.

Activities included in this service
are not primarily directed at
teaching specific job skills, but
at underlying habilitative goals,
such as attention span and motor
skills. All prevocational services
will be reflected in the
individual's plan of care as
directed to habilitative, rather
than explicit employment
objectives.

Documentation will be maintained in
the file of each individual
receiving this service that:

1. The service is not otherwise
available under a program
funded under the
Rehabilitation Act of 1973, or
P.L. 94-142; and
2. ~~The individual has been~~

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~~deinstitutionalized from a
SNF, ICF, NF, or ICF/MR at
some prior period.~~

_____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

 X

Supported employment services, which consist of paid employment ~~consisting of 10 or more hours a week, paid at 50% of minimum wage, or higher~~ for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support ~~services for less than 50% of their employment hours~~ to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid

work by individuals receiving waiver services, including supervision and training, job coach, employment specialist services, personal assistance and consumer-run businesses. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
- ~~2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.~~

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. X Yes 2. No

Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization of the participant. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

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h. X Environmental accessibility adaptations:
 (**``Environmental Modifications``**)

_____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

 X Other service definition (Specify):
Those physical adaptations to the home and work environment, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and work environment and without which, the recipient would require institutionalization. Home adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems

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which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, and the like. Also excluded are the costs for construction in a new home or new construction (e.g., additions) in an existing home. Central air conditioning may be covered only when prescribed by a physician, and specified with extensive documentation in the plan of care as to how it is essential in the treatment of the participant's illness or condition. That documentation must also show that central air is cost effective as compared to the cost of window units in all rooms required or to be used by the participant. Work environment adaptations include only those necessary to accommodate the waiver participant's individualized needs, and shall not be used to supplant the requirements of Section 504 of the Social Security Act or the Americans with Disabilities Act or covered by the Michigan Rehabilitation Services. All services shall be provided in accordance with applicable State or local building codes. Assessments and specialized training needed in the conjunction with the use of environmental modifications are included as part of the cost of the service.

Environmental modifications for licensed settings, may include only the remaining balance of previous environmental modifications costs, in so far as they accommodate the specific disabilities of the current waiver residents, and will be limited to the documented portion being amortized in the mortgage or lease cost per bed. Environmental Modifications shall exclude costs of those modifications required for basic Foster Care Licensure, or to meet local building codes. This service is necessary to

prevent the institutionalization of the person served. The cost-effectiveness of this service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

i. _____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. _____ Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

_____ Other service definition (Specify):

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k. X Specialized Medical Equipment and Supplies: (**Enhanced Medical Equipment and Supplies**)

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

 X Other service definition (Specify):

Enhanced medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase, maintain or improve their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service is necessary to prevent institutionalization. This coverage includes adaptations to vehicles as well as other items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

Generators may be covered for an individual who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the recipient. Coverage excludes furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home; items that are considered family recreational choices; purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle; and educational supplies that are required to be provided by the school as specified in the child's Individualized Education Plan. All items shall meet applicable standards of manufacture, design and installation. The cost-effectiveness of this service is demonstrated in Appendix G. All items must be prescribed and justified by a physician as essential to the health, welfare, safety and greater independent functioning of the participant and shall be specified in the participant's plan of supports/services. Assessments and specialized training needed in conjunction with the use of such devices and equipment, as well as required upkeep and repair shall be covered as a part of the cost of the service.

1. X Chore services:

 X Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, support/service provider, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

 Other service definition (Specify):

m. X Personal Emergency Response Systems (PERS)

 X PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day, and have no regular ~~caregiver~~ support/service provider for extended periods of time, and who would otherwise require extensive routine supervision and guidance.

 Other service definition (Specify):

n. _____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

o. X Private duty nursing

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

 X Other service definition (Specify):
Private Duty Nursing services provided to individuals age 21 and older up to a maximum of 16 hours per day that consist of nursing procedures to meet an individual's health needs directly related to his developmental disability, including the provision of nursing treatments and observation provided by licensed nurses within the scope of the

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State's Nurse Practice Act consistent with physicians' orders. The individual receiving private duty nursing must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver: community living supports, out-of-home non-vocational habilitation, prevocational, or supported employment.

The PIHP must determine the extent to which the individual's health needs, as described in I or II, require nursing procedures as described in III. The PIHP must find that the participant meets the criteria of either I and III listed below, or II and III listed below. Private Duty Nursing services are necessary to prevent institutionalization.

I. The participant is dependent daily on technology-based medical equipment to sustain life. ``Dependent daily on technology-based medical equipment means:

- mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or
- oral or tracheostomy suctioning eight or more times in a 24-hour period; or
- nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

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- total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

II. Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III. Below) due to a substantiated medical condition directly related to the developmental disability.

Definitions:

- "frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
- "medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical

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condition. ``Emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- ``directly related to the developmental disability'' means an illness, diagnosis, or syndrome that occurred during the developmental period prior to age 22, is likely to continue indefinitely and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
- ``substantiated'' means documented in the clinical/medical record, including the nursing notes.

NOTE: For beneficiaries described in II. above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care.

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III. The participant requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- ``Continuous'' means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- ``Skilled nursing'' means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

These services should be provided to a participant at home or in the community. A physician's prescription is required.

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The PIHP must assess and document the availability of all private health care coverage for private duty nursing and will assist the participant in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a participant.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hour per day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care; and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

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Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:

The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:

("Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.)

("Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.)

("Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home help provider or Community Living Supports staff.

NOTE: This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

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- A temporary increase in the intensity of required assessments, judgments, and interventions.
- A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- In the event there is only one caregiver living in the home with the beneficiary and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital or in the event of an acute illness or injury of the primary caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.

- The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.

- The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of

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	<u>hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.</u>
--	--

NOTE: Private Duty Nursing is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility and, therefore, private duty nursing services covered by this waiver are not available to that age group.

Private Duty Nursing services are necessary to prevent institutionalization. The cost effectiveness of this service is demonstrated in Appendix G. Provider Qualifications are found in Appendix B-2.

p. X Family training:

 X Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, unpaid caregivers or in-laws. "Family" does not include individuals who are employed to care provide waiver services for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates

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as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

_____ Other service definition (Specify):

q. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the

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safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements
(Specify):

_____ Other service definition (Specify):

r. _____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed____).

Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility.

This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the

independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- ☐ Home health care
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Medication administration
- ☐ Intermittent skilled nursing services
- ☐ Transportation specified in the plan of care
- ☐ Periodic nursing evaluations
- ☐ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

☐ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. _____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- _____ Physician services
- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- X Prescribed drugs **``Enhanced Pharmacy``**
- _____ Other State plan services (Specify):

Enhanced Pharmacy: Physician ordered, nonprescription "medicine chest items" as specified in the plan of care. Only the following items are allowable:

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cough/cold/pain/headache/ allergy and gastro-intestinal distress remedies; vitamin and mineral supplements; special dietary juices and foods that augment, but do not replace, a regular diet; thickening agents for safe swallowing when the participant has a diagnosis of dysphagia and either a) recent history of aspiration pneumonia within the past year or b) documentation that the participant is at risk of insertion of a feeding tube without thickening agents for safe swallowing; first aid supplies (i.e. band aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); special oral care products to treat specific oral conditions beyond routine mouth care (i.e. special toothpastes, tooth brushes, anti-plac rinses, antiseptic mouthwashes); and special items (i.e. accommodating common disabilities - longer, wider handles) tweezers and nail clippers. These items are not covered under Michigan's State Plan, not considered part of routine room and board costs, are required for decent level of personal hygiene, and, from a health and hygiene maintenance perspective, are considered necessary to prevent institutionalization. Routine cosmetic products (i.e. base, blush, mascara, and similar products) will not be covered under Enhanced Pharmacy. However, products or prostheses necessary to ameliorate negative visual impact of serious facial disfigurements (absence of ear, nose, or other feature, massive scarring,) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered.

~~Enhanced Dental~~ [*ELIMINATE SERVICE*]: These services are accepted dental procedures provided as specified in the plan of service after all state plan dental coverages have

been sought and exhausted, and, to only those individuals with dental problems which are sufficient to lead to more generalized disease due to infection or improper nutrition which would require institutionalization.

t. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Community Living Supports: Community Living Supports facilitate an individual's independence and promote integration into the community. Community Living Supports can be provided in the participant's residence (licensed facility, family home, own home or apartment) or in community settings and may not supplant other Waiver or state plan covered services (e.g., Out-of-Home Nonvocational Habilitation, Home Help Program, Personal Care in Specialized Residential, Respite).

Community Living Supports includes:

A. Assisting* [see note below], reminding, observing, guiding and/or training in the following activities:

- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living such as bathing, eating, dressing, personal hygiene
- shopping for food and other necessities of daily living

B. Assistance, support and/or training with such activities as:

- money management
- non-medical care (not requiring nurse or physician intervention)
- socialization and relationship building
- transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community

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- activities, and from the community activities back to the participant's residence
 - leisure choice and participation in regular community activities
 - attendance at medical appointments
 - acquiring or procuring goods other than those listed under shopping, and non-medical services
- C. Reminding, observing and/or monitoring of medication administration

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through the Department of Human Services (DHS) or the Medicaid Health Plan.

*Note on assisting with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping:
CLS services may not supplant state plan services, such as Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). Therefore, if such assistance is needed, the participant, with the help of the PIHP supports coordinator must request Home Help, and if necessary Expanded Home Help, from DHS. CLS may be used for those activities while the participant awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP supports coordinator must assist, if necessary, the participant in filling out and sending a request for Fair Hearing when the participant believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect the participant's needs based on the findings of the DHS assessment.

CLS assistance with meal preparation, laundry,

routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined by to exceed the DHS's allowable parameters. CLS may also be used for those activities while the participant awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports do not include the cost associated with room and board. Payment for Community Living Supports does not include payments made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

The cost effectiveness of this service is demonstrated in Appendix G. Provider qualifications are found in Appendix B-2. This service is necessary to prevent the institutionalization of the person served.

u. _____ Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

_____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State

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law),

- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically

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excluded from Medicaid payment for
psychosocial rehabilitation
services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services,
and
- d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in
a facility) are services defined in 42 CFR
440.90.

Check one:

_____ This service is furnished only on
the premises of a clinic.

_____ Clinic services provided under this
waiver may be furnished outside the
clinic facility. Services may be
furnished in the following
locations (Specify):

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APPENDIX B-2**PROVIDER QUALIFICATIONS****A. LICENSURE AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
1. Chore Services	Enrolled Mental Health Clinic Services Agency Private Contractor	n/a	n/a	Previous relevant experience/training/skills in heavy housekeeping chores *
2. Respite Care	Enrolled Mental Health Clinic Services Agency Trained Individuals* Foster Care Provider	n/a 	Services may be provided in or out-of-home. - Competencies/credentials consistent with those of the primary caregiver(s)* - MCL [^] 400.701 (Adult); MCL 722.122 (Children); [Foster Care Licensure]

* Trained individuals performing chore, respite care, habilitation, and/or community living supports must, in addition to the specific training, supervision and standards for each support/service, be:

- Responsible adults, at least 18 years of age;
- Free from communicable disease;
- Able to read and follow written plans of service/supports as well as participant-specific emergency procedures
- Able to write legible progress and/or status notes;
- In "good standing" with the law, (i.e., not a fugitive from justice, a convicted felon or an illegal alien);
- Able to perform basic first aid and emergency procedures.

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Respite Care (cont'd)	Licensed Nurse	Michigan License as a Registered Nurse or Licensed Practical Nurse		- MCL 333.17201 from PA368 of 1978 [Nursing Licensure]
3. Private Duty Nursing	Enrolled Mental Health Clinic Services Agency Licensed Nurse	Michigan License as a Registered Nurse or Licensed Practical Nurse	n/a	- MCL 333.172 Nursing Licensure
4. Enhanced Medical Equipment & Supplies	Enrolled Mental Health Clinic Services Agency Enrolled Medical Suppliers	n/a	n/a	Enhancement of a Medicaid State Plan Coverage - Medicaid Provider Manual, Medical Equipment and Supplies SectionsV
5. Enhanced Pharmacy	Enrolled Mental Health Clinic Services Agency Enrolled Pharmacy Providers	n/a	n/a	Enhancements of a Medicaid State Plan Coverage - Medicaid Provider Manual, Pharmacy SectionV - MCL 333.7303a Licensed Prescriber
6. Environmental Modifications	Enrolled Mental Health Clinic Services Agency Licensed Contractors	Licensed Contractors	n/a	- MCL 339.601(1) Residential Builders - MCL 339.601.2404(3) Maintenance Alteration - Local Building Ordinances/ Codes

▽ Michigan's Medicaid Provider manuals function in place of Administrative Rules and have the force and effect of law.

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Family Training (cont'd) Trained Individuals*	Competence by the American Speech and Hearing Association or working toward CCC and supervised by a CCC-SLP Under the supervision of a psychologist, social worker, QMRP, OT, PT, or Speech Therapist
8. Supports Coordination	Enrolled Mental Health Clinic Services Agency - Supports Coordinator	n/a	n/a	- Minimum of bachelor's degree in a human services field and one year of experience working with persons w/ devopmental disabilities, e.g. meets the qualifications of a QMRP as defined in 42 CFR 483.430 - Minimum of equivalent experience (i.e. provides knowledge, skills and abilities similar to Support Coordinator qualifications); functions under the supervision ¹ of a degreed Support Coordinator

1 Supervision means the professional overseeing another's work is available by phone for consultation and there is evidence of regularly-scheduled and occurring meetings between the professional and person being supervised. The supervisory relationship and responsibilities are reflected in the relevant job descriptions.

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Supports Coordination (cont'd)	- Supports Broker				
9. Community Living Supports	Enrolled Mental Health Clinic Services Agency Trained Individuals*	n/a	n/a	As specified in the plan of service MDCH/PIHP Contract Guidelines MCL 330.1200 thru 330.1246, Administrative Rules, MI Mental Health Code Chapter 2 and 7	- Selected by participant, demonstrates competence in areas of job responsibilities for supports broker; functions under the supervision of a degreed Support Coordinator
10. Out-of-Home Nonvocational Habilitation	Enrolled Mental Health Clinic Services Agency Licensed/Registered Professionals as applicable Trained Individuals *	See Family Training for all professionals' licensure & certification requirements	See Family Training for all professionals' licensure & certification requirements	See Family Training for all professionals' other standards Modified definition does not alter standards: MCL330.1200 thru 330.1248 and Administrative Rules, MI Mental Health Code MDCH/PIHP contract guidelines	
11. Prevocational Services	Enrolled Mental Health Clinic Services Agency Work Activity Center	n/a	n/a	- Professional Staff Licensing, PA 368 as amended and Admin. Rules - MCL330.1200 thru 330.1248 and Administrative Rules, MI Mental Health Code - DCH/PIHP contract Guidelines - Work Activity Certification; US Dept of Labor; Fair Labor Standards Act Section 14(c) (facility) - Commission on Accreditation of Rehabilitation Facilities Standards	
12. Supported Employment	Enrolled Mental Health Clinic Services Agency QMRP	n/a	n/a	- Trained job coach or QMRP as defined in 42 CFR 483.430; or trained individual supervised by QMRP.	

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Supported Employment (cont'd)	Trained Individual *			
				<ul style="list-style-type: none"> - MCL330.1200 thru 330.1248 and Administrative Rules, MI Mental Health Code - DCH/PIHP Contract Guidelines Fair Labor Standards Act, US Dept of Labor - 34 CFR Sec. 363
13. Personal Emergency Response Systems	Enrolled Mental Health Clinic Services Agency - Medicare/Medicaid Home Health Agencies - Hospitals - PERS Providers	n/a	n/a	Medicaid Home Health Agency Provider Manual MCL 333.21501 (Hospitals) MCL 338.1051 (Alarm Systems)
14. Enhanced Dental	Enrolled Mental Health Clinic Services Agency			

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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

A separate 1915(b) waiver request which included a waiver of freedom of choice of providers and established criteria for those providers was approved. The 1915(c) waiver operates concurrently with the 1915(b) waiver.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- _____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- X A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

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APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan.
(Check all that apply.)

1. X Low income families with children as described in section 1931 of the Social Security Act.
2. X SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. X Optional State supplement recipients
5. X Optional categorically needy aged and disabled who have income at (Check one):
 - a. X 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.

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- 6.____ The special home and community-based waiver group under 42 CFR 435.217
(Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

____ A. Yes ____ B. No

Check one:

- a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
- b.____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)____ A special income level equal to:

____ 300% of the SSI Federal benefit (FBR)

____% of FBR, which is lower than 300% (42 CFR 435.236)

\$____ which is lower than 300%

(2)____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)____ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4)____ Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

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(5)___ Aged and disabled who have income at:

a. ___ 100% of the FPL

b. ___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ___ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

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Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

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- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

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POST ELIGIBILITY

REGULAR POST ELIGIBILITY

- 1.____ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.
- A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.
- a. Allowances for the needs of the
1. individual: (Check one):
- A.____ The following standard included under the State plan (check one):
- (1)____ SSI
- (2)____ Medically needy
- (3)____ The special income level for the institutionalized
- (4)____ The following percent of the Federal poverty level):____%
- (5)____ Other (specify):

- B.____ The following dollar amount:
\$____*
- * If this amount changes, this item will be revised.
- C.____ The following formula is used to determine the needs allowance:

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Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ☐ SSI standard

B. ☐ Optional State supplement standard

C. ☐ Medically needy income standard

D. ☐ The following dollar amount:
\$ _____*

* If this amount changes, this item will be revised.

E. ☐ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

F. ☐ The amount is determined using the following formula:

G. ☐ Not applicable (N/A)

3. Family (check one):

A. ☐ AFDC need standard

B. ☐ Medically needy income standard

The amount specified below 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 income standard established under 435.811 for a family of the same size.

C. ☐ The following dollar amount:

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\$ ____ *

*If this amount changes, this item will be revised.

D. ____ The following percentage of the following standard that is not greater than the standards above: % of ____ standard.

E. ____ The amount is determined using the following formula:

F. ____ Other

G. ____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

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POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___ **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan
(check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income
level for the institutionalized

(4)___ The following percentage of
the Federal poverty level: ___ %

(5)___ Other (specify):

B. ___ The following dollar amount:
\$ ___ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

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Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.____ The following standard under 42 CFR 435.121:

B.____ The medically needy income
standard_____;

C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be
revised.

D.____ The following percentage of the following standard that is
not greater than the standards above:_____ % of

E.____ The following formula is used to determine the amount:

F.____ Not applicable (N/A)

3. family (check one):

A.____ AFDC need standard

B.____ Medically needy income
standard

The amount specified below 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 income standard established under 435.811
for a family of the same size.

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C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

E.____ The following formula is used to determine the amount:

F.____ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

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POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)____ SSI Standard

(b)____ Medically Needy Standard

(c)____ The special income level for the institutionalized

(d)____ The following percent of the Federal poverty level: ____%

(e)____ The following dollar amount
\$ ____ **

**If this amount changes, this item will be revised.

(f)____ The following formula is used to determine the needs allowance:

(g) Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

- ☐ Discharge planning team
- ☐ Physician (M.D. or D.O.)
- ☐ Registered Nurse, licensed in the State
- ☐ Licensed Social Worker
- ☒ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
- ☐ Other (Specify):

APPENDIX D-2**a. REEVALUATIONS OF LEVEL OF CARE**

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- _____ Every 3 months
- _____ Every 6 months
- X Every 12 months
- _____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

- X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- _____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):
 - _____ Physician (M.D. or D.O.)
 - _____ Registered Nurse, licensed in the State
 - _____ Licensed Social Worker
 - _____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
 - _____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- X "Tickler" file
- X Edits in computer system
- Component part of case management
- X Other (Specify): MDCH reviews PIHP Waiver eligibility (LOC)
certification files during site review visits on a biennial
basis.

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

☒ By the Medicaid agency in its central office Maintains records of new enrollments

☐ By the Medicaid agency in district/local offices

☐ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

☐ By the case managers

☒ By the persons or agencies designated (the PIHPs) as responsible for the performance of evaluations and reevaluations

☐ By service providers

☐ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

Michigan requires an eligibility certification format containing a common set of eligibility information. See ATTACHMENT D-1 (HSW Eligibility Certification Form). The Prepaid Inpatient Health Plans (PIHPs) and their affiliate Community Mental Health Services Programs (CMHSPs) are required to certify each individual's eligibility on such a format, and to use state DD Center admissions standards that include the "Developmental Disability" definition of the Developmental Disabilities Assistance and Bill of Rights Act as the basis for their evaluation and reevaluations of the person's need for the ICF/MR level of care (but for the availability of home and community-based services). For all persons requesting new enrollment, the eligibility Certification Form (LOC) and supporting documentation are reviewed and approved by MDCH staff who are QMRPs. Recertification of the LOC is completed by the PIHP on an annual basis.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- ☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons
- ☐ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

1. <input type="checkbox"/> Initial Certification		2. <input type="checkbox"/> Annual Recertification	
3. _____ Name	4. _____ Medicaid Number	5. _____ PIHP I.D. Number (optional)	
6. _____ Address	7. _____ City and Zip Code	8. _____ Birth Date	
9. _____ Prepaid Inpatient Health Plan (PIHP)	10. _____ PIHP Medicaid Provider ID #	11. _____ County of Financial Responsibility (MANDATORY)	

Waiver Recommendation: 12. ☐ Waiver Recommended 13. ☐ Waiver Not Recommended

14. _____ 15. _____
 Supports Coordinator Signature & Credentials Date Other PIHP Staff (Optional) Date

16. ☐ This person is developmentally disabled as defined in the Developmental Disabilities Assistance and Bill of Rights Act;
AND

17. ☐ But for the availability of home and community-based services, this person would require the level of care provided by an intermediate care facility for the mentally retarded.

Waiver Recommendation: 18. ☐ Waiver Recommended 19. ☐ Waiver Not Recommended

20. _____ 21. _____
 QMRP Signature & Credentials Date PIHP Designee: (Optional) Date

I understand that I may accept or reject waiver services instead of services provided in an ICF/MR and that I may withdraw this consent at any time by submitting my withdrawal in writing. This consent may not exceed 36 months. I accept/reject services as offered under the Home and Community-Based Waiver. (Circle One)

22. _____ 23. ☐ Legal Guardian/Parent of Minor 24. ☐ Consumer
Signature Date

25. _____
Witness 1 Date

26. _____
Witness 2 Date

Two witnesses required if signature is made by a mark (X).

Waiver Enrollment

28. ☐ Person is enrolled; effective: 29. _____ OR ☐ Person is re-certified; effective: 30. _____

Person's enrollment status; 30a. ☐ Deinstitutionalized 30b. ☐ Diverted Date: 31.

32. ☐ Person is not eligible for enrollment; reason: 33. _____

34. ☐ Enrollment terminated; effective: 35. _____ Notice of right to fair hearing given; date 35a. _____

Reason for termination: 36. _____

37. _____
 PIHP Designee Signature (for recertifications & disenrollments) -OR-
 MDCH Signature (for new enrollments) _____ Date _____

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice. A separate 1915(b) waiver request which included a waiver of freedom of choice of providers and established criteria for those providers was approved. Per state policy, procedures are specified related to notice of right to fair hearing. HSW participants may also use the local grievance and appeal process in conjunction with fair hearing that is an attachment to the MDCH/PIHP contract.
3. The following are attached to this Appendix information is provided:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing; ATTACHMENT D-1, Section 3 documents the person's (or their legal guardian's) freedom of choice to accept waiver services instead of ICF/MR. Notices of right to fair hearing are provided in compliance with the MDCH/PIHP Agreement, located in Attachment P6.3.2.1R of the Agreement.
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver: HSW enrollees and their legal representatives are informed of the feasible alternatives available under the waiver based on the identified outcomes in the initial and ongoing person-centered planning (PCP) activities per the MDCH/PIHP Agreement located in

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Attachment P3.4.1.1 Person-Centered Planning Revised Policy Guideline. The information is given to the enrollee and the legal representative, if applicable, by the HSW supports coordinator. The alternatives selected by the enrollee are documented in the individual plan of services (POC).

- c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services: At the time of initial certification for application to the HSW and for subsequent re-certifications once enrolled, the individual or legal representative are advised of their option to choose ICF/MR services or the home and community-based services provided by the HSW. Agreement with the selection of HSW services is noted in Section 3 of the Eligibility Certification Form (see Attachment D-1).

and

- d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Notices of right to fair hearing are provided in compliance with the MDCH/PIHP Agreement, located in Attachment P6.3.2.1R of the Agreement. At the point where an individual requests enrollment into the HSW, the PIHP or its affiliate CMHSP partner is responsible for completing the initial screening and HSW Eligibility Certification Form. If the PIHP determines that the person is eligible for the HSW, an enrollment packet is completed and submitted to MDCH central office staff for review and approval. If an enrollment packet is submitted to MDCH, then MDCH will provide written adequate notice of right to fair hearing if it is determined that the person does not meet eligibility criteria for enrollment into the HSW. If, however, the PIHP determines that an enrollment packet will not be submitted to MDCH, either because the person does not appear to meet eligibility criteria, or because there are no available HSW slots in the PIHP, then the PIHP will provide the person with an adequate notice of right to fair hearing.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Copies of the Waiver Certification Form (LOC) that documents
freedom of choice are maintained at the PIHP for a minimum of
three years and are available for review by MDCH.

Prepared by mary clarkson 64650
date: 04-20-95
disk: streamlining
opus-3-d

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

_____ Social Worker (qualifications attached to this Appendix)

_____ Case Manager

 X Other (specify): The Supports Coordinator possesses a bachelor's degree in a human service field and has at least one year experience in serving persons with developmental disability.

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

_____ By case managers

_____ By the agency specified in Appendix A

_____ By consumers

 X Other (specify): At the Prepaid Inpatient Health Plan (PIHP) or affiliate Community Mental Health Services Program (CMHSP) or agency contracting with the PIHP for the provision of waiver services and supports.

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3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

- ☐ Every 3 months
- ☐ Every 6 months
- ☒ Every 12 months The plan may be reviewed at any time when requested by the HSW enrollee, but at a minimum must be reviewed at least once per year.
- ☐ Other (specify):

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APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

MDCH completes a comprehensive biennial site visit to all PIHPs and reviews a random sample of clinical records, as well as visits to participants' homes. The complete description of this process has been provided to CMS during the review prior to this renewal application. A summary of quality management strategies is located in Appendix H.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

No standardized form is required. Plans of supports and services will contain the information identified in b-1 above to specify the type of service, the amount, frequency and duration, and the type of provider.

The State employs the following planning process for supports and services under the Home and Community Based (Habilitation Supports) Waiver. Each participant will have a person-centered planning meeting involving those individuals chosen by the participant. Using the person-centered planning processes, an Individual Plan of Services is developed that specifies the supports and/or the services the participant will receive. Each participant will also receive supports coordination services to assist him/her in the planning process and to organize the planning team that consists of individuals chosen by the participant, as well as monitoring both the supports/service delivery and the health and safety of the participant as a part of their regular contacts with the participant. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

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The person-centered planning team that will assist the participant to identify the needed HSW supports and services will include: the waiver participant; the supports coordinator; guardian, if applicable; the parent of a minor child; other interested or involved people as chosen by the participant; any professionals as required by the desires or identified needs of the participant, or due to other regulatory requirements. The Individual Plan of Service that is developed from the person-centered planning process must be reviewed according to the schedule determined by the planning committee to meet the participant's needs and updated as necessary, but at least annually.

prepared by mary clarkson 64650
date: 04-25-95
disk: streamlining
opus-3-e

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX F - AUDIT TRAIL

A. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services inclusive of those operating as or under the auspices of an Organized Health Care Delivery System (OHCDs) and/or a Prepaid Inpatient Health Plan (PIHP).
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):
 - ☐ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).
 - ☐ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
 - ☐ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.
 - ☒ Other (Describe in detail): Pre-paid capitation payments for each HSW enrollee are made to the PIHP on a monthly basis. Separate capitation payments are sent to the PIHPs for other mental health services under the 1915(b) waiver.

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B. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services 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 approved plan of care;
- c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

☒ Yes

☐ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

☒ All claims are processed through an approved MMIS as capitated payments.

☐ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

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C. PAYMENT ARRANGEMENTS

1. Check all that apply:

- ☒ The Medicaid agency will make payments directly to providers of waiver services inclusive of OHCDSS and/or PIHPs.
- ☐ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.
- ☐ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

☐ Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency. Documentation of compliance with OHCDSS/PIHP requirements by applicable Waiver providers are on file at the Department of Community Health.

prepared by mary clarkson 64650
date: 01-20-95
disk: streamlining
opus-3-f

STATE: MICHIGAN

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APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>\$39,776</u>	<u>\$19,984*</u>	<u>\$159,370</u>	<u>\$1,847</u>
2	<u>\$41,154</u>	<u>\$19,712</u>	<u>\$164,608</u>	<u>\$1,996</u>
3	<u>\$42,560</u>	<u>\$20,387</u>	<u>\$170,019</u>	<u>\$2,158</u>
4	<u>\$44,037</u>	<u>\$21,085</u>	<u>\$175,607</u>	<u>\$2,333</u>
5	<u>\$45,546</u>	<u>\$21,807</u>	<u>\$181,379</u>	<u>\$2,522</u>

* includes prescription drug costs for Medicare/Medicaid Dual eligible for first quarter of year one, ending 12/31/05. All projected costs from 1/1/06 forward exclude the cost of prescription drug for enrolled beneficiaries who are eligible for Medicare Part D benefits.

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FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR UNDUPLICATED INDIVIDUALS

1 8,268

2 8,268

3 8,268

4 8,268

5 8,268

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

 X The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

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APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

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APPENDIX G-2
 FACTOR D LOC: ICF/MR

STATE OF MICHIGAN WAIVER # 0167.90.R2.01

DEMONSTRATION OF FACTOR D ESTIMATES

Waiver Year: 1 X 2 _____ 3 _____ 4 _____ 5 _____

COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E
WAIVER SERVICE NAME	Unduplic'd # of Users Using Svcs.	Average # And Type Units / User Per Year	Ave. Cost Per Unit	Total Cost B x C x D
COMM LIVING SUPP-PER 15 MIN	3,145	8,041 15 Min	\$3.98	\$100,650,001
COMM LIVING SUPP-PER DIEM	4,431	350 Day	\$87.99	\$136,459,292
OUT-OF-HOME NONVOC HABILITATION	4,833	3,196 15 Min	\$3.22	\$49,736,983
PREVOCATIONAL SVCS	515	540 Hour	\$11.21	\$3,117,501
SUPPORTED EMPLOYMENT SVCS	1,399	1,669 15 Min	\$3.76	\$8,779,341
RESPIRE CARE	541	1,894 15 Min	\$3.38	\$3,463,331
PRIVATE DUTY NURSING	38	1,841 Hour	\$36.89	\$2,580,751
CHORE SVCS	4	436 15 Min	\$4.57	\$7,970
PERS	114	11.5 Month	\$568.69	\$745,553
ENVIRON MODIFICATIONS	47	1 Service	\$653.90	\$30,733
ENH MED EQUIP & SUPPLIES	443	2 Item	\$233.50	\$206,881
ENH PHARMACY	1,295	11.5 Item	\$60.57	\$902,039
FAMILY TRAINING	132	4 Session	\$123.54	\$65,229
SUPPORTS COORDINATION	8,144	38 15 Min	\$71.48	\$22,121,059
GRAND TOTAL (Sum of Column E)				\$328,866,662
FACTOR C (Total Number of Unduplicated Recipients)				8,268
FACTOR D (Per Capita Ave. Cost to Medicaid): Grand Total of E Divided by Factor C:				\$39,776

AVERAGE LENGTH OF STAY: 95.83% or 11.5 Months.

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APPENDIX G-2
 FACTOR D LOC: ICF/MR

STATE OF MICHIGAN WAIVER # 0167.90.R2.01

DEMONSTRATION OF FACTOR D ESTIMATES

Waiver Year: 1 ____ 2 X 3 ____ 4 ____ 5 ____

COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E
WAIVER SERVICE NAME	Unduplic'd # of Users Using Svcs.	Average # And Type Units / User Per Year	Ave. Cost Per Unit	Total Cost B x C x D
COMM LIVING SUPP-PER 15 MIN	3,145	8,041 15 Min	\$4.12	\$104,190,453
COMM LIVING SUPP-PER DIEM	4,431	350 Day	\$91.02	\$141,158,367
OUT-OF-HOME NONVOC HABILTATION	4,833	3,196 15 Min	\$3.33	\$51,436,072
PREVOCATIONAL SVCS	515	540 Hour	\$11.60	\$3,225,960
SUPPORTED EMPLOYMENT SVCS	1,399	1,669 15 Min	\$3.89	\$9,082,882
RESPIRE CARE	541	1,894 15 Min	\$3.50	\$3,586,289
PRIVATE DUTY NURSING	38	1,841 Hour	\$38.16	\$2,669,597
CHORE SVCS	4	436 15 Min	\$4.73	\$8,249
PERS	114	11.5 Month	\$588.31	\$771,274
ENVIRON MODIFICATIONS	47	1 Service	\$676.46	\$31,794
ENH MED EQUIP & SUPPLIES	443	2 Item	\$241.56	\$214,022
ENH PHARMACY	1,295	11.5 Item	\$62.66	\$933,164
FAMILY TRAINING	132	4 Session	\$127.80	\$67,478
SUPPORTS COORDINATION	8,144	38 15 Min	\$73.95	\$22,885,454

GRAND TOTAL (Sum of Column E) \$340,261,057

FACTOR C (Total Number of Unduplicated Recipients) 8,268

FACTOR D (Per Capita Ave. Cost to Medicaid): Grand Total of E Divided by Factor C: \$41,154

AVERAGE LENGTH OF STAY: 95.83% or 11.5 Months.

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APPENDIX G-2
 FACTOR D LOC: ICF/MR

STATE OF MICHIGAN WAIVER # 0167.90.R2.01

DEMONSTRATION OF FACTOR D ESTIMATES

Waiver Year: 1 _____ 2 _____ 3 X 4 _____ 5 _____

COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E
WAIVER SERVICE NAME	Unduplic'd # of Users Using Svcs.	Average # And Type Units / User Per Year	Ave. Cost Per Unit	Total Cost B x C x D
COMM LIVING SUPP-PER 15 MIN	3,145	8,041 15 Min	\$4.26	\$107,730,906
COMM LIVING SUPP-PER DIEM	4,431	350 Day	\$94.16	\$146,028,036
OUT-OF-HOME NONVOC HABILITATION	4,833	3,196 15 Min	\$3.44	\$53,135,162
PREVOCATIONAL SVCS	515	540 Hour	\$12.00	\$3,337,200
SUPPORTED EMPLOYMENT SVCS	1,399	1,669 15 Min	\$4.03	\$9,409,772
RESPIRE CARE	541	1,894 15 Min	\$3.62	\$3,709,247
PRIVATE DUTY NURSING	38	1,841 Hour	\$39.48	\$2,761,942
CHORE SVCS	4	436 15 Min	\$4.90	\$8,546
PERS	114	11.5 Month	\$608.61	\$797,888
ENVIRON MODIFICATIONS	47	1 Service	\$699.80	\$32,891
ENH MED EQUIP & SUPPLIES	443	2 Item	\$249.89	\$221,403
ENH PHARMACY	1,295	11.5 Item	\$64.82	\$965,332
FAMILY TRAINING	132	4 Session	\$132.21	\$69,807
SUPPORTS COORDINATION	8,144	38 15 Min	\$76.50	\$23,674,608
GRAND TOTAL (Sum of Column E)				\$351,882,738
FACTOR C (Total Number of Unduplicated Recipients)				8,268
FACTOR D (Per Capita Ave. Cost to Medicaid): Grand Total of E Divided by Factor C:				\$42,560

AVERAGE LENGTH OF STAY: 95.83% or 11.5 Months.

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APPENDIX G-2

STATE OF MICHIGAN WAIVER # 0167.90.R2.01

FACTOR D LOC: ICF/MR

DEMONSTRATION OF FACTOR D ESTIMATES

Waiver Year: 1 _____ 2 _____ 3 _____ 4 X 5 _____

COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E
WAIVER SERVICE NAME	Unduplic'd # of Users Using Svcs.	Average # And Type Units / User Per Year	Ave. Cost Per Unit	Total Cost B x C x D
COMM LIVING SUPP-PER 15 MIN	3,145	8,041 15 Min	\$4.41	\$111,524,247
COMM LIVING SUPP-PER DIEM	4,431	350 Day	\$97.41	\$151,068,299
OUT-OF-HOME NONVOC HABILITATION	4,833	3,196 15 Min	\$3.56	\$54,988,714
PREVOCATIONAL SVCS	515	540 Hour	\$12.41	\$3,451,221
SUPPORTED EMPLOYMENT SVCS	1,399	1,669 15 Min	\$4.16	\$9,713,313
RESPIRE CARE	541	1,894 15 Min	\$3.74	\$3,832,206
PRIVATE DUTY NURSING	38	1,841 Hour	\$40.84	\$2,857,085
CHORE SVCS	4	436 15 Min	\$5.06	\$8,825
PERS	114	11.5 Month	\$629.61	\$825,419
ENVIRON MODIFICATIONS	47	1 Service	\$723.94	\$34,025
ENH MED EQUIP & SUPPLIES	443	2 Item	\$258.51	\$229,040
ENH PHARMACY	1,295	11.5 Item	\$67.06	\$998,691
FAMILY TRAINING	132	4 Session	\$136.77	\$72,215
SUPPORTS COORDINATION	8,144	38 15 Min	\$79.14	\$24,491,614
GRAND TOTAL (Sum of Column E)				\$364,094,913
FACTOR C (Total Number of Unduplicated Recipients)				8,268
FACTOR D (Per Capita Ave. Cost to Medicaid): Grand Total of E Divided by Factor C:				\$44,037

AVERAGE LENGTH OF STAY: 95.83% or 11.5 Months.

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APPENDIX G-2
 FACTOR D LOC: ICF/MR

STATE OF MICHIGAN WAIVER # 0167.90.R2.01

DEMONSTRATION OF FACTOR D ESTIMATES

Waiver Year: 1 _____ 2 _____ 3 _____ 4 _____ 5 X

COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E
WAIVER SERVICE NAME	Unduplic'd # of Users Using Svcs.	Average # And Type Units / User Per Year	Ave. Cost Per Unit	Total Cost B x C x D
COMM LIVING SUPP-PER 15 MIN	3,145	8,041 15 Min	\$4.56	\$115,317,589
COMM LIVING SUPP-PER DIEM	4,431	350 Day	\$100.77	\$156,279,155
OUT-OF-HOME NONVOC HABILITATION	4,833	3,196 15 Min	\$3.68	\$56,842,266
PREVOCATIONAL SVCS	515	540 Hour	\$12.84	\$3,570,804
SUPPORTED EMPLOYMENT SVCS	1,399	1,669 15 Min	\$4.31	\$10,063,553
RESPIRE CARE	541	1,894 15 Min	\$3.87	\$3,965,411
PRIVATE DUTY NURSING	38	1,841 Hour	\$42.25	\$2,955,726
CHORE SVCS	4	436 15 Min	\$5.24	\$9,139
PERS	114	11.5 Month	\$651.33	\$853,894
ENVIRON MODIFICATIONS	47	1 Service	\$748.92	\$35,199
ENH MED EQUIP & SUPPLIES	443	2 Item	\$267.43	\$236,943
ENH PHARMACY	1,295	11.5 Item	\$69.37	\$1,033,093
FAMILY TRAINING	132	4 Session	\$141.49	\$74,707
SUPPORTS COORDINATION	8,144	38 15 Min	\$81.87	\$25,336,473
GRAND TOTAL (Sum of Column E)				\$376,573,950

FACTOR C (Total Number of Unduplicated Recipients) 8,268

FACTOR D (Per Capita Ave. Cost to Medicaid): Grand Total of E Divided by Factor C: \$45,546

AVERAGE LENGTH OF STAY: 95.83% or 11.5 Months.

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APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

All of the HSW services, with the exception of Out-Of-Home Nonvocational Habilitation, Prevocational, and Supports Employment Services may be provided in residential settings as described above. With the exception of respite services provided in a foster home or community residential facility meeting state-specified standards, room and board is not allowed as a part of a waiver service.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

There are adult HSW participants living in the family home and a parent may be a paid caregiver for an HSW service such as Community Living Supports. Room and board is not allowed as a part of a waiver service except as noted in A. above.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Per the DCH/PIHP Agreement, Section 9.3, MDCH will conduct reviews and audits of the PIHP regarding performance. These reviews and audits will focus on PIHP compliance with state and federal laws, rules, regulations, policies, and waiver

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provisions, in addition to contract provisions and
PIHP/CMHSP policy and procedure.

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APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN
UNRELATED LIVE-IN CAREGIVER

Check one:

 X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

 The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State 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.

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State Plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

- _____ Based on HCFA Form 2082 (relevant pages attached).
- _____ Based on HCFA Form 372 for years _____ of waiver
_____, which serves a similar target population.
- _____ Based on a statistically valid sample of plans of care
for individuals with the disease or condition specified
in item 3 of this request.
- x _____ Other (specify): Based on MMIS data equivalent to the
information previously required on the CMS 372 long
form, i.e. Medicaid cost for all other services
provided to individuals in the waiver program divided
by the unduplicated count of the Waiver beneficiaries
who used and/or received them. The costs of
prescription drugs for dual eligible individuals who
will be covered by Medicare Part D effective 1/1/06
have been backed out from the State's projections.

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- _____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- _____ Based on trends shown by HCFA Form 372 for years ____ of waiver #_____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- _____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- _____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- X Other (specify): Based on MMIS data equivalent to the information previously required for CE Formula Factor B on the 372 long form, i.e. total ICF/MR expenditures divided by the unduplicated count of ICF/MR beneficiaries

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

- ☐ Based on HCFA Form 2082 (relevant pages attached).
- ☐ Based on HCFA Form 372 for years _____ of waiver # _____, which serves a similar target population.
- ☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- ☒ Other (specify): Based on MMIS data equivalent to the information previously required for Cost Effectiveness formula element B' on the 372 long form, that is, the Medicaid expenditures for all services other than those included in Factor B (ICF/MR services), divided by the unduplicated count of the ICF/MR beneficiaries who used/received them. The costs of prescription drugs for dual eligible individuals who will be covered by Medicare Part D effective 1/1/06 have been backed out of the State's projections. The impact of removing dual eligibles from G' was negligible.

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D: \$39,776

FACTOR G: \$159,370

FACTOR D': \$19,984

FACTOR G': \$ 1,847

TOTAL: \$59,759 ≤

TOTAL: \$161,217

YEAR 2

FACTOR D: \$41,154

FACTOR G: \$164,608

FACTOR D': \$19,712

FACTOR G': \$ 1,996

TOTAL: \$60,866 ≤

TOTAL: \$166,605

YEAR 3

FACTOR D: \$42,560

FACTOR G: \$170,019

FACTOR D': \$20,387

FACTOR G': \$ 2,158

TOTAL: \$62,947 ≤

TOTAL: \$172,177

STATE: MICHIGAN

DATE: OCTOBER 1, 2005

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: ICF/MR

YEAR 4

FACTOR D: \$44,037FACTOR G: \$175,607FACTOR D': \$21,085FACTOR G': \$ 2,333TOTAL: \$65,122 \leq TOTAL: \$177,940

YEAR 5

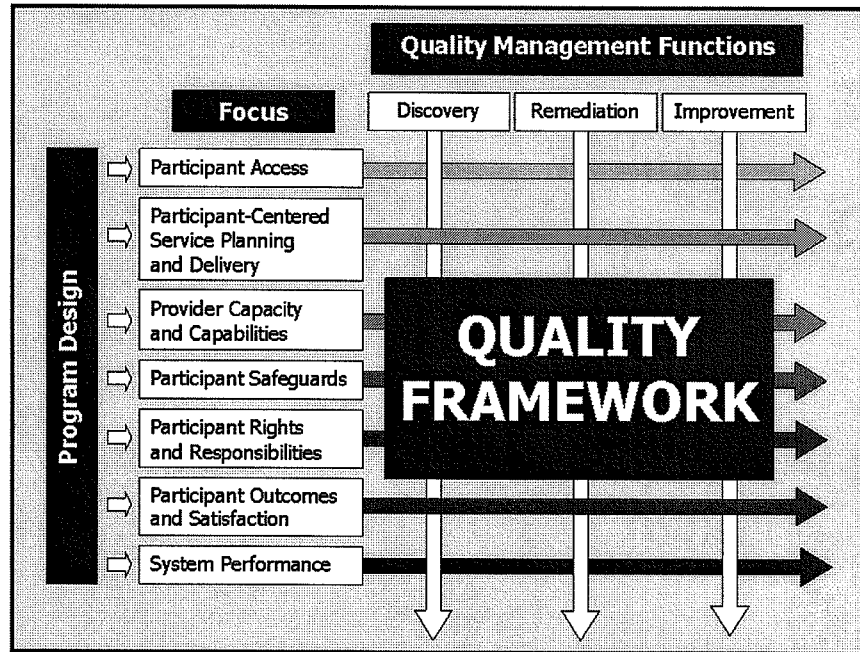
FACTOR D: \$45,546FACTOR G: \$181,379FACTOR D': \$21,807FACTOR G': \$ 2,522TOTAL: \$67,353 \leq TOTAL: \$183,901

prepared by mary clarkson 64650
date: 12-22-94 revised 04-13-95
disk: hcbs
opus-3-g

STATE: MICHIGANDATE: OCTOBER 1, 2005

Appendix H: Quality Management Strategy

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 operation. 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 Management 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. A Quality Management Strategy is explicit about the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management 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 go 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 the waiver assurances articulated in 42 CFR §441.301 and §441.302.

It may be more efficient and effective for a Quality Management 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 services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H.

The Quality Management Strategy must describe how the state will determine that each waiver assurance is met. The description must include:

- Activities or processes related to discovery i.e. monitoring and recording the findings. *
- Roles and responsibilities of those involved in measuring performance and making improvements. Include administrative entities identified in Appendix A, and individuals, advocates, providers, etc.
- The sources of data used to measure performance.
- The frequency with which performance is measured.

* Descriptions of monitoring/over sight activities that occur at the individual and provider level of service delivery have been provided in the application in Appendices B, C, D, G, and I. These monitoring activities provide a foundation for QM by generating information that can be aggregated and analyzed to measure the overall performance of the system. The description of the QM Strategy does not have to repeat those descriptions provided in other parts of the waiver application.

The Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement

The Quality Management Strategy must describe how the state compiles quality management information and communicates this information (in report or other forms) to participants, families, waiver providers, other interested parties, and the public, including the frequency of dissemination. The Quality Management Strategy must include periodic evaluation and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.

If the State's Quality Management Strategy 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management Strategy spans more than one waiver and/or other types of long-term services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

**STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED
SPECIALTY SERVICES AND SUPPORTS**

Revision 6/30/05

The following strategy is designed to assess and improve the quality of specialty services and supports managed by the prepaid inpatient health plans (PIHPs). The state agency responsibility for the components of the quality management system listed here resides in the Michigan Department of Community Health's (MDCH) Division of Quality Management and Planning, except where otherwise noted.

I. BACKGROUND: PROCESS FOR QUALITY STRATEGY REVIEW AND REVISION

This quality strategy builds upon and improves the initial strategy developed for the 1915(b)(c) waiver application in 1997, and revised for each subsequent waiver renewal application. As with these previous quality strategies, this quality strategy was developed with the input of consumers and the Mental Health Quality Improvement Council that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health services Boards. This revised and improved strategy also reflects the activities, concerns, input or recommendations from the Michigan Mental Health Commission, MDCH's Encounter Data Integrity Team, MDCH's Administrative Simplification Process Improvement Team, the 2005 External Quality Review, and the terms and conditions from CMS' previous waiver approval.

II. CERTIFICATION, ACCREDITATION, AND LICENSURE

A. Community Mental Health Services Program Certification: The approved Plan for Procurement and the subsequent Application for Participation (2002) required that each PIHP be a community mental health services program (CMHSP). The Michigan Mental Health Code (Code) requires that every CMHSP be certified by the Michigan Department of Community Health (MDCH) in order to receive funds. The certification consists of two elements:

1. Each CMHSP must be determined to have a local recipient rights system that is in substantial compliance with the requirements of the Recipient Rights Chapter 7 of the Code. This compliance is determined by on-site visitation by the MDCH Office of Recipient Rights.
2. Each CMHSP must be compliance with a set of organizational standards established in Michigan's Administrative Rules, which have the effect of law. The rules cover the following dimensions:
Governance, mission statement, community education, improvement of program quality, personnel and resource management, physical/ therapeutic environment, fiscal management, consumer information, education and rights, eligibility and initial screening, waiting lists, alternative services, array of services, medication and individual plan of service.

It is required that the CMHSP and each of its subcontracting providers of mental health services meet these standards. If a CMHSP or its subcontracting provider is accredited by a national organization, a limited review of the accredited agency is conducted by MDCH beyond assuring the existence of said accreditation.

MDCH has granted deemed status to four national accrediting bodies: Joint Commission on Accreditation of Health Care Organizations (JCAHO), CARF, The Council on Accreditation (COA), and The Council.

Certification may be granted for up to three years. CMHSPs must be certified prior to entering into a pre-paid contract for services and supports for beneficiaries.

In order to screen children for inpatient hospitalization or out-of-home placement, CMHSPs must meet the Children's Diagnostic and Treatment Services Programs certification requirements. CDTSPs are assessed and re-certified every three years.

B. Provider Networks:

1. Community Mental Health Services Programs as "Affiliates" and other providers: Affiliates and sub-contracting providers must meet the certification requirements stated in A above.
2. Substance Abuse Treatment Providers: PIHPs subcontract with Substance Abuse Coordinating Agencies (CAs) to manage the substance abuse treatment benefit. Five PIHPs are CAs. CAs are not licensed or accredited for ongoing treatment services, but all of their subcontracting providers of outpatient, residential, intensive outpatient, sub-acute residential and methadone substance abuse services are required to be licensed under the Michigan Public Health Code. CAs must be appropriately licensed if operating their own central diagnostic and referral service. In addition, state and federal funds administered by MDCH for treatment services may be contracted only with licensed providers accredited by one of the following national accrediting bodies: JCAHO, CARF, COA, National Council on Quality Assurance (NCQA) and the American Osteopathic Association (AOA). Licensing actions are the responsibility of the Michigan Department of Community Health, Bureau of Health Systems who consults with the CAs and MH&SA Administration and reports all licensing findings to the administration.

Persons seeking substance abuse treatment must be authorized by a professional assessor. In completing the assessment, the American Society for Addiction Medicine (ASAM) Patient Placement Criteria must be applied to determine the appropriate level of treatment. These criteria are also employed for continuing stay and discharge decisions by the treatment and/or assessment program.

3. Certification and Licensing for Settings Where Services are Provided:
 - a. Specialized Mental Health Residential Certification: All adult residential

service providers who receive funds for the provision of specialized mental health services must be certified by Michigan Department of Human Services (MDHS). These standards address issues such as: accessibility, facility environment, fire safety, and staffing levels and qualifications. Specifically, these rules require that all staff who work independently and who function as lead workers must complete training which covers eight areas, including the role of residential care workers, introduction to the special needs of adults with developmental disabilities and mental illness, basic interventions for maintaining and caring for a recipient's health, basic first aid and CPR, medications, environmental emergencies, recipient rights, and non-aversive techniques for preventing or managing challenging behaviors. While these rules do not require a schedule of retraining, PIHPs will be required to assure that these staff be retrained whenever the treatment needs of the resident(s) change and whenever there is a significant change in MDCH policy which would affect the delivery of services. In addition, PIHPs are required as part of the CMHSP certification to have a local process to assure that persons providing services and supports are competent to perform their duties.

- b. **Adult Foster Care Licensing:** The MDHS also acts as the licensing agent for Adult Foster Care settings. Formal mechanisms of communication exist between MDHS and MDCH to share information regarding the findings from the respective settings. For example, licensing problems identified by MDHS are forwarded to MDCH for follow up as part of its contractual or site visit processes. PIHPs, in turn, and/or their subcontracting provider networks have the responsibility to report potential problems to the MDHS for follow up.
 - c. **Protective Services:** MDHS also has responsibility for Adult and Child Protective Services. PIHPs along with their subcontracting provider networks have a legal responsibility to report potential violations to the local MDHS offices.
4. **Coordination On Issues Involving Adult Foster Care Settings**
- a. Staff from MDCH Mental Health and Substance Abuse Administration meet monthly with MDHS central office staff to share information, jointly revise policies, and trouble-shoot on various issues including self-determination, individuals' own homes, state plan home help services, critical incidents and sentinel events. One outcome of the group is an agreement that there need to be new requirements in MDCH/PIHP contracts for improving local coordination agreements with local DHS offices regarding roles and responsibilities in adult and children's protective services, adult and children's foster care licensing, recipient rights, sentinel events.

III. APPLICATION FOR PARTICIPATION (AFP) & CONTRACTUAL REQUIREMENTS FOR PIHPS' QUALITY MANAGEMENT SYSTEMS

Three areas addressed by the 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 MDCH/PIHP contracts; and they are reviewed by MDCH staff and/or the external quality review process.

A. CUSTOMER SERVICES

Customer services is required by the MDCH/PIHP contract to be an identifiable function of the PIHP that operates to enhance the relationship with the community as well as with the beneficiary. Customer services is frequently a function delegated by the PIHP to affiliates or providers, including the substance abuse network. When delegated, the PIHP must monitor the entity to which the function is delegated.

The following customer services minimum standards are covered by the MDCH on-site visit or the EQR: [Note: items starred are covered by the EQR]

- Customer services operation is clearly defined and facilitates
 - Phone access throughout normal business hours*
 - Staff are knowledgeable regarding benefits, provider network, policies and procedures regarding access, service authorization, grievances and appeals mechanisms, and are skilled in customer relations*
 - Process to collect and transmit service and process improvement suggestions*
 - Integration of beneficiaries and family members into the operation*
- Customer service staff are knowledgeable about referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT)*
- 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's network
- Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP*
- The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice.
- Customer services is managed in a way that assures timely access to customer 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*
- The relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined organizationally and managerially in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.*

PIHPs found out of compliance with these standards must submit plans of correction. MDCH staff and the EQRO follow-up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council (QIC). Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for

system improvements.

B. APPEALS AND GRIEVANCES MECHANISMS

CMS approved the BBA revision of the appeals and grievance procedures, required by MDCH/PIHP contract. The EQR reviews on-site 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 on-site review by MDCH. MDCH uses its Appeals database to track the trends of the requests for fair hearing and their resolution and to identify PIHPs that have particularly high volumes of appeals. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council). Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

C. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS

The MDCH contracts with PIHPs require that the CMS-approved Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented). The EQR monitors on-site the PIHPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: VIII Sentinel Events and XI Credentialing of providers. MDCH collects data for Standard VI. Performance Indicators, VII Performance Improvement Projects, and XII Medicaid Services Verification as described below.

1. Performance Indicators

Please see section VI.A of this Quality Strategy

2. Performance Improvement Projects

The Mental Health and Substance Abuse Management Team, the Quality Improvement Council, and Division of Quality Management and Planning staff collaborate to identify the performance improvement projects for the each waiver period. Justification for the projects was derived from analyses of quality management data, external quality review findings, and stakeholder concerns.

For the upcoming waiver period Michigan's will require all PIHPs to conduct a minimum of two performance improvement projects:

- a. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH as identified above. In the case of PIHPs with affiliates, the project is affiliation-wide and includes substance abuse treatment services.
- b. PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHPs choose a performance improvement project in consultation with the QAPIP governing body.

PIHPs report semi-annually on their performance improvement projects. The EQR validates the PIHPs methodologies for conducting the projects. Results of

the MDCH performance improvement project reports are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

3. Medicaid Services Verification

PIHPs are required to develop and maintain a system for verifying that Medicaid services identified in the plan of service, and billed, were actually rendered. PIHPs submitted their plans for the Medicaid verification system to MDCH for initial approval in 2001 and are periodically asked to resubmit their methodologies. PIHPs report to MDCH annually on the results of their Medicaid verification systems.

IV. EXTERNAL QUALITY REVIEW

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the EQR for two years, beginning June 2004. HSAG worked with MDCH and representatives from the PIHPs to adapt the Year One review protocols for Michigan. A similar approach will be employed for Year Two (June 2005-June 2006) and Year Three (June 2006-June 2007) of the EQR. The EQR consists of desk audits of PIHP documents and two-day on-site visits to each PIHP.

The contents of the review for Years One, Two and Three are:

A. Validation of Performance improvement projects:

1. For FY'04, the EQR focused on the methods PIHPs employed to implement the MDCH required project – Improvement of Coordination of Care with Primary Health Care Providers and the Medicaid Health Plans
2. For the future, HSAG will focus on correction of problems with methodology identified in year one.

B. Validation of performance indicators:

1. Year one the EQR looked at data collection methods and performed an ISCA
2. In the future the EQR will follow-up on problems identified in year one and validate performance indicators for the current period.

C. Compliance with Michigan's Quality Standards per BBA

1. In the first year the EQR focused on the following standards:
 - a. Quality Assessment and Performance Improvement Plan and Structure (See Attachment A)
 - b. Performance measurement and improvement
 - c. Practice guidelines
 - d. Staff qualification and training
 - e. Utilization management
 - f. Customer services
 - g. Recipient grievance process
 - h. Recipient rights and protections
2. In the future the EQR will address:
 - a. Subcontracts and delegation
 - b. Provider networks
 - c. Access and availability
 - d. Coordination of care and care management

- e. Psychiatric advanced directives
- f. Service authorization and appeals
- g. Credentialling
- h. Follow-up on any areas found in need of improvement from the second review

Results of the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

V. MDCH ON-SITE REVIEW OF PIHPS: REVISED PROCESS FOR FY'06

MDCH proposes to conduct comprehensive biennial site visits to all PIHPs. During the alternate years PIHPs will be visited by state staff to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. As with the previous quality strategy, this site visit strategy incorporates for all beneficiaries served by the specialty waiver the more rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries, including visits to beneficiaries' homes. The comprehensive reviews include the following components:

A. Clinical Record Review

Reviews of clinical records to determine that person-centered planning is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and delivery of service meet program requirements that are published in the Medicaid Provider Manual.

Random samples of clinical records to be reviewed are drawn by the MDCH review team from encounter data in the MDCH warehouse. Limited advanced notice is provided to PIHPs about the records selected for review. An additional set of randomly-selected records are requested without advance notice after the team has arrived on-site. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs, all affiliates (if applicable), a sample of providers, and an over-sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

B. Administrative Review

The comprehensive administrative review will focus on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH/PIHP contract requirements and might include:

- o Compliance with the Medicaid Provider Manual
- o Written agreements with providers, community agencies
- o The results of the PIHPs' annual monitoring of its provider network
- o Adherence to contractual practice guidelines
- o Sentinel event management

C. Consumer/Stakeholder Meetings

During the biennial comprehensive review the team will meet with a group of

consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered planning, employment, recovery, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the PIHP's responsiveness to the group's concerns and suggestions.

D. Consumer Interviews

Review team members will conduct interviews with a sample of those individuals 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, access to transportation, psychiatric advanced directives, and satisfaction with services. Interviews will be conducted where consumers live for persons residing in group homes or persons living independently with intense and continuous in-home staff. Interviews of other consumers may be conducted in the PIHP office or over the telephone.

A report of findings from the on-site reviews with scores will be disseminated to the PIHP with requirement that a plan of correction be submitted to MDCH in 30 days. Reports on plans of correction will be submitted to MDCH. On-site follow-up will be conducted the following year, or sooner if non-compliance with standards is an issue.

Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Overall PIHP site review responsibility is located in the Division of Quality Management and Planning. The PIHP site review team is composed of a minimum of four MDCH staff: a registered nurse, a clinical professional, an analyst, and an individual who has a mental illness, developmental disability, or is the family member of an individual with a disability. The Division of Substance Abuse Treatment provides additional staff to conduct the portion of the review that focuses on the PIHP's Medicaid Substance Abuse treatment program. The Office of Mental Health Services to Children and Families provides additional staff to conduct the portion of the review that focused on the Children's Waiver (Home and Community Based Waiver.).

VI. DATA SUBMISSION AND ANALYSES

A. Performance Indicators

Medicaid performance indicators measure the performance of the PIHPs. The specific Medicaid performance indicators (listed in Attachment A) have been extracted from the more comprehensive Michigan Mission-Based Performance Indicator System that has evolved since 1997 based on adoption of core indicators by national organizations or federal agencies (e.g., Center for Mental Health Services and Center for Substance Abuse Treatment). The performance indicators were revised in 2005 by the Quality Improvement Council. The indicators are categorized by domains that include access, adequacy,

appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP issues that need to be addressed immediately; to suggest that there are trends to be watched; 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 and QI data located in MDCH's data warehouse. Any data that are submitted by PIHPs, and the methodologies for doing so, are validated by MDCH and the EQR. Analyses of the data result in comparisons among PIHPs and with statewide averages. Statistical outliers are determined for the identification of best practices or conversely, opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, leading up to PIHP contract action. Technical information from the performance indicators is shared with the PIHPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

B. Encounter and Quality Improvement Data

Demographic characteristics as well as summary encounter data have been reported to MDCH annually for each mental health service recipient since the early 1990's. Individual level demographic data, and admission and discharge records for persons receiving substance abuse treatment services have been collected by MDCH since 1980. Beginning in FY'03, individual level encounter data were reported electronically in HIPAA-compliant format each month for all services provided in the previous month and for which claims have been adjudicated. "Quality improvement" or demographic data were also reported monthly for each individual. Data are stored in MDCH's data warehouse where Medicaid Health Plan and Pharmacy encounter data are also stored. MDCH mental health and substance abuse staff with access rights to the warehouse analyze mental health, substance abuse, pharmacy and health plan data to evaluate appropriateness of care, over- and under-utilization of services, access to care for special populations, and the use of state plan service versus 1915(b)(3) services.

Aggregate data from the encounter data system are shared with MDCH Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

C. Medicaid Sub-element Cost Data

PIHPs are required by contract to submit Medicaid sub-element cost reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided, by PIHP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDCH to crosscheck the completeness and accuracy

of the encounter data. Cost data are shared with MDCH Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

D. Sentinel Events

Sentinel events involving persons who receive Targeted Case Management, or are enrolled in the Habilitation Supports Waiver, or live in 24-hour specialized residential settings, or live in their own homes receiving ongoing and continued personal care services are reported, reviewed, investigated and acted upon at the local level by each PIHP or its delegated agent. This information is reported in the aggregate to the MDCH semi-annually. Sentinel events include but are not limited to: death of the recipient, any accident or physical illness that requires hospitalization, suspected abuse and neglect of a recipient, incidents that involve arrest or conviction of the recipient, serious challenging behaviors (e.g., property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence) and medication errors.

Michigan law and rules require the mandatory reporting of the issues above to the Adult Foster Care Licensing Division of MDHS within 48 hours for persons in licensed residential settings, and to the CMHSPs' Office of Recipient Rights for all others. There is specific language in law to establish the duty to report to law enforcement suspected abuse and neglect. The reporting of sentinel events is the primary responsibility of residential workers for persons in licensed settings, and case managers or supports coordinators for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to PIHPs.

Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

E. Recipient Rights

Local CMHSP offices of recipient rights report semi-annually summaries of numbers of allegations received, number investigated, number in which there was an intervention, and the numbers that were substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, right protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state Office of Recipient Rights and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSP exist. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

F. Service Agency Profiles

CMHSPs are required to submit to MDCH information about each of their Medicaid service providers at least every three years and is update in the interim for changes to providers: addition of new providers, termination of contracts, change in accreditation status, change of address. This information is kept in a data base and is used by the Mental Health and Substance Abuse Administration to verify the capacity of the service network.

VII. STATE WIDE SURVEYS

The Michigan Legislature's Appropriations Act for MDCH requires that an annual survey of consumer satisfaction be conducted. MDCH targets a statewide probability sample of adult Medicaid beneficiaries who received mental health, developmental disabilities, or substance abuse treatment. The sample receives a mailed copy of SAMHSA's Mental Health Statistical Improvement Program consumer survey. The Participant Experience Survey (PES) is being pilot- tested on adults with developmental disabilities. MDCH expects to use the PES in the FY'06 consumer satisfaction survey. The Quality Improvement Council in partnership with MDCH will develop a strategy for moving from a statewide probability sample to representative samples at each PIHP in order to distinguish the relative satisfaction of respondents by PIHP. The strategy would be implemented for the next waiver period.

The Michigan Department of Community Health has been awarded a 3-year data infrastructure grant (DIG) by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to prepare Michigan's community mental health agencies for the systematic, on-going measurement of outcomes for adults with mental illness and the use of these outcome measurements for managing the treatments, services, and supports provided to consumers. The initiative represents a response both to national trends and to concerns expressed by the Governor's Commission on Mental Health, the MDCH Quality Council, and the Evidence-based Practice Steering Committee that Michigan does not, on a statewide basis, evaluate the outcomes of care as part of its overall quality management strategy. This addition to the quality assessment initiative will allow the State to provide convincing evidence to important stakeholders that public mental health services are helpful to consumers and their families. It also will provide our treatment professionals at the local level important information that can inform clinical judgment and help improve the quality of publicly provided mental health care. The DIG Outcomes Measurement Initiative will be undertaken as a collaboration between the Michigan Department of Community Health (MDCH), the Michigan Association of Community Mental Health Boards (MACMHB), the State's 46 community mental health services programs (CMHSPs) and 18 prepaid inpatient health plans (PIHPs). During Year 1, an Outcomes Measurement Advisory Committee will work with MDCH to select, test and evaluate a set of outcome measurements. These measures will be evaluated through the assistance of CMHSP clinicians and caseworkers. During Years 2 and 3, the selected measure(s) will be implemented state-wide as part of a contractual requirement.

VIII. MENTAL HEALTH SYSTEMS TRANSFORMATION

- a. Mental Health and Substance Abuse Administration (MH&SA) began its systems transformation initiative in the spring of 2004 in response to the President's New Freedom Initiative, and to Michigan's Mental Health Commission Recommendations. MH&SA is promoting the development or enhancements of local PIHP and subcontractor organizational cultures that adopt evidence based practices, and evaluate and continuously improve existing practices.
- b. A steering committee of MH&SA staff, mental health consumers, and representatives from the PIHPs, major state universities, and mental health advocacy organizations determined that PIHPs would be required to implement either Family Psycho-Education (FPE) or Integrated Treatment for Co-Occurring Disorders (COD) in 2005-06. Mental Health Block Grant funds will be provided to each PIHP to initiate their projects: community organizing and staff training. Block Grant funds have also been set aside for training for each EBP in the fall of 2005. Universities are assisting with evaluation of the projects. Fidelity to the models will be monitored by MDCH.
- c. PIHPs are also encouraged to implement Parent Management Training this year. MDCH has issued a competitive RFP offering Mental Health Block Grant funds for supporting a limited number of PIHPs in their implementation.
- d. MH&SA Administration has also embarked on projects to improve ACT and supported employment during the 2005-07 period.
- e. MH&SA Administration has assembled a group of developmental disabilities advocates and clinicians to plan improvements and strategies for implementing them in services and supports for persons with developmental disabilities.

IX. PHARMACY QUALITY IMPROVEMENT PROJECT

MDCH has received a grant from the Eli Lilly Corporation to implement a pharmacy quality improvement project. Comprehensive NeuroScience (CNS) is analyzing pharmacy claims for Medicaid beneficiaries who use psychotropic medications to review prescribing practices of physicians and patient adherence to prescriptions. The outcomes of the project are to improve continuity of care, eliminate redundant treatments, coordinate care among providers, and decrease risks associated with inappropriate use. Prescribing physicians will have access to peer psychiatrists for consultation about improved practices. Results from the project will be available in 2006.

X. CONTRACT COMPLIANCE REVIEW AND ACTION

- A. PA 597: Standards And Sanctions For PIHPs: In response to Public Act 597, enacted by the Michigan Legislature, MDCH is developing a set of managed care standards by which to measure the PIHPs' performance and a set of sanctions to impose when performance is sub-standard
- B. Contract Action
The controlling document to assure that quality mental health and substance abuse services will be maintained is the contract between the MDCH and the PIHPs. The contract includes specific language regarding issues of general compliance, the compliance review process, and the dispute resolution process.

Specific language allows for emergency reviews by MDCH whenever there is an allegation of fiscal impropriety, or endangerment of health and safety of beneficiaries. The contracts make clear that MDCH may utilize a variety of remedies and sanctions, ranging from the issuance of a corrective action plan to withholding payment to contract cancellation.

Attachment A

**MEDICAID SPECIALTY SUPPORTS AND SERVICES
PERFORMANCE INDICATORS FOR PIHPS
Revised May 2005 by the Quality Improvement Council**

1. The percent of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition (decision) was completed within three hours for MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities. Standard = 95% of decisions are made within three hours.
2. The percent of persons receiving a face-to-face meeting with a professional for the purposes of screening, assessment or services within 14 calendar days of a non-emergency request for service from MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders. Standard = 95% of persons receive a face-to-face meeting within 14 calendar days.
3. The percent of persons starting any needed on-going service within 14 calendar days of a non-emergent assessment with a professional for MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders. Standard = 95% of persons receive at least one service within 14 calendar days of the assessment.
4. The percent of persons discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days for MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders. Standard = 95% are seen for follow-up care within seven days.
5. The percent of total Medicaid recipients receiving PIHP managed mental health services by PIHP by population: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders.
6. The percent of Habilitation Supports Waiver enrollees who received at least one additional service besides supports coordination each month.
7. The percent of total annual Medicaid expenditures spent on managed care administration by PIHP.
8. The percent of adults with mental illness and adults with developmental disabilities in competitive employment during the year.
9. The percent of adults with mental illness and adults with developmental disabilities who earned minimum wage or more from employment activities.
10. The percent of persons readmitted to a psychiatric inpatient unit within 30 days of discharge from a psychiatric inpatient unit. Standard = 15% or less are readmitted. Population covered: MI adults, children with SED, adults with

developmental disabilities, and children with developmental disabilities.

11. The number of substantiated recipient rights complaints per thousand persons served annually in the categories of Abuse I and II and Neglect I and II.

Population covered: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities.

12. The number of sentinel events per thousand persons served annually.

Population covered: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders.