DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 1, 2023

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

RE: §1915(c) Waiver MI.0233.R06 and §1915(b) Waiver MI-0018.R02

Dear Director Groen:

The Centers for Medicare & Medicaid Services (CMS) is approving your request to renew Michigan's MI Choice home and community-based services (HCBS) waiver for individuals who are ages 65 and older or 18 and older with disabilities. This waiver will provide HCBS for individuals who, absent the waiver, would require care in a nursing facility. This waiver is assigned control number MI.0233.R06, which should be referenced in all future correspondence relating to this program. This approval does not relieve the state of its obligations under the Americans with Disabilities Act (ADA) and the Olmstead decision.

Concurrently, CMS is approving Michigan's request to renew its §1915(b) MI Choice waiver with CMS control number MI-0018.R02. This waiver allows for the mandatory enrollment of all §1915(c) MI Choice enrollees into twenty prepaid ambulatory health plans for the provision of services approved under the §1915(c) waiver, as well non-emergency medical transportation services authorized under the state plan. This §1915(b) waiver is authorized under §1915(b)(1) and §1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following sections of Title XIX:

- Section 1902(a)(10)(B) Comparability
- Section 1902(a)(23) Freedom of Choice

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all the statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The §1915(c) waiver will offer the following services:

- Adult Day Health
- Respite

- Supports Coordination
- Specialized Medical Equipment and Supplies
- Fiscal Intermediary
- Goods and Services
- Supports Brokerage
- Assistive Technology
- Chore Services
- Community Health Worker
- Community Living Supports
- Community Transportation
- Counseling
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Nursing Services
- Personal Emergency Response System
- Private Duty Nursing/Respiratory Care
- Residential Services
- Training
- Vehicle Modifications

The following estimates of utilization and cost have been approved:

Waiver Year	Unduplicated Recipients	Average Cost per Participant (Factor D)	Total Waiver Costs
WY1 10/1/2023 – 9/30/2024	19824	$21867.73	$433,505,880
WY2 10/1/2024 – 9/30/2025	20196	$22557.28	$455,566,827
WY3 10/1/2025 – 9/30/2026	20568	$23279.12	$478,804,940
WY4 10/1/2026 – 9/30/2027	20940	$24129.09	$505,263,145
WY5 10/1/2027 – 9/30/2028	21312	$24987.76	$532,539,141

These waivers are effective for five years, operating concurrently, with the §1915(c) waiver beginning December 01, 2023 and ending November 30, 2028, and the §1915(b) waiver beginning December 01, 2023 and ending September 30, 2028. The state may request renewal of these authorities by providing evidence and documentation of satisfactory performance and oversight. Michigan should submit to CMS the request that these authorities be renewed no later than July 3, 2028.

The state will report all managed care waiver expenditures on the CMS 64-9 and §1915(c) waiver expenditures on the CMS 372 report. Separate 372 reports should be submitted for the time the waiver was on extension. Michigan is also responsible for documenting cost-effectiveness, access, and quality in subsequent renewal requests.

On a quarterly basis, the state is required to submit to CMS the previous quarter's member months by approved Medicaid eligibility group (MEG) on the attached "1915(b) Worksheet for State Reporting of Member Months." The report is due 30 days after the end of each quarter and should be submitted to the DMCO Actions mailbox, MCGDMCOActions@cms.hhs.gov. The state should also conduct its own quarterly calculations using Tab D6 of the approved §1915(b) Waiver Cost-Effectiveness Worksheets and request an amendment to the waiver should the state discover the waiver's actual costs are exceeding projections. Additionally, the state must submit a waiver amendment to reflect any major changes impacting the program, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, quality/access, and/or monitoring plan.

The Appendix K amendment that included provisions incorporated via this renewal expires November 30, 2023.

We appreciate the cooperation and effort provided by you and your staff during the review of these waiver renewals. If you have any questions concerning this information, please contact Krystal Duffy at (410) 786-5235 or via email at Krystal.Chatman@cms.hhs.gov for the §1915(c) waiver or Eowyn Ford at (312) 886-1684 or via email at Eowyn.Ford@cms.hhs.gov for the §1915(b) waiver.

Sincerely,

George Failla, Director
Division of HCBS Operations and Oversight

Bill Brooks, Director
Division of Managed Care Operations

cc: Jacqueline Coleman, MDHHS
Cynthia Nanes, DHCBSO
Aimee Campbell-O'Connor, DMCO
Krystal Duffy, DHCBSO
Eowyn Ford, DMCO

Enclosure: §1915(b) Worksheet for State Reporting of Member Months

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

The substantive changes MDHHS is making in this waiver renewal are:

1. Revised performance measures
2. Increased number of waiver slots for unduplicated number of participants and the number of participants served in the program at any point in time.
3. Require that a person-centered planning meeting occur every 180 days in lieu of 180-day reassessment
4. Require initial assessments to be conducted in person. Subsequent reassessments may be conducted virtually with camera on if the participant chooses this method. Participant privacy must be protected if using the virtual with camera method. Assessments and reassessments conducted only by telephone will not be allowed. Virtual assessments with video will also be allowed if an applicant or participant is transferring from a nursing facility that is out of service area or a waiver agency in a different service area. In those situations, the assessment can be initiated but is not considered complete until the individual moves and the in-person assessment is completed in the new domicile.
5. Separation of Residential Services (congregate living settings) from Community Living Supports (CLS). Residential Services is a new service.
6. Separation of Assistive Technology from Specialized Medical Equipment and Supplies. Assistive Technology is a new service.
7. Allow spouses and legally responsible adults to be paid caregivers for Community Living Supports in limited situations.
8. Change Home Delivered Meals (HDM) service parameters to no longer require the need to be able to feed oneself.
9. Allow HDM to include meal delivery kits such as Hello Fresh, Blue Apron, etc., as an option. HDM will also include grocery delivery services (service fees, not the groceries).
10. Restructure the quality withhold repayment process to focus on improved performance rather than compliance.
11. Addition of critical incidents that the waiver agencies are required to report: Eviction, Suicide/suicide attempts/self-harm, Missing person/elopement.
12. Diversity, equity and inclusion training for waiver agency staff and recommended for network providers.
13. Allow CLS services to be provided in the hospital under limited circumstances to participants who are hospitalized.
14. Allow additional qualifications for supports coordinators: licensed psychologists, physical therapists, and occupational therapists.
15. Changed timeframe for resolution of critical incidents to 90 days instead of 60 days. RESPONSES TO IRAI 8/9/2023: THIS CHANGE WAS MADE AFTER THE PUBLIC INPUT PROCESS BASED ON PROPOSED CHANGES IN FEDERAL REGULATIONS THAT WERE RELEASED FOR PUBLIC COMMENT FOR MAY AND JUNE 2023.

CHANGES MADE IN RESPONSE TO RAI:
- ADDED VEHICLE MODIFICATIONS AS A SERVICE
- ADDED SUPPORTS BROKERAGE AS A SERVICE
- REMOVED LANGUAGE IN MAIN MODULE ATTACHMENT #2
- MADE OTHER LANGUAGE CHANGES AS INDICATED BY "IN RESPONSE TO RAI"
- CHANGED EFFECTIVE DATE OF THE WAIVER RENEWAL TO 12/1/2023
- COST NEUTRALITY DATA CHANGED DUE TO CHANGE IN EFFECTIVE DATE OF WAIVER YEAR 1 TO 12/1/2023

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

1. Request Information (1 of 3)

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

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

MI Choice Waiver Renewal

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MI.0233
Waiver Number:MI.0233.R06.00
Draft ID: MI.003.06.00

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

Regular Waiver

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

12/01/23

Approved Effective Date: 12/01/23

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

MI Choice is limited to serving older adults (age 65 and older) and persons with disabilities (age 18 and older).

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

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

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

1. Request Information (3 of 3)

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

Select one:

- ○ **Not applicable**
- ◉ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☒ **Waiver(s) authorized under §1915(b) of the Act.**

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

A 1915(b) waiver application will be submitted concurrently with this 1915(c) waiver renewal application. The Control Number for the 1915(b) waiver is MI.0018.R02.00

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

- ☒ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☒ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

MI Choice is a § 1915(c) waiver used to deliver home and community based services to elderly and disabled individuals meeting Michigan's nursing facility level of care who, but for the provision of such services, would require nursing facility services. The goal is to provide home and community based services and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. The waiver is administered by the Michigan Department of Health and Human Services (MDHHS), Behavioral and Physical Health and Aging Services Administration (BPHASA), which is the Single State Medicaid Agency. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations.

MI Choice is a Medicaid managed care program. MI Choice participants receive services from entities classified as Prepaid Ambulatory Health Plans (PAHPs), herein referred to as waiver agencies. MDHHS contracts with waiver agencies to carry out its waiver obligations. Each waiver agency must sign a provider agreement with MDHHS assuring that it meets all program requirements.

Waiver agencies may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under subcontract with the waiver agency must meet provider standards described elsewhere in the waiver application. Subcontracts also assure that providers of services receive full reimbursement for services outlined in the waiver application. Providers meeting the requirements outlined in the waiver are permitted to participate.

MI Choice operates concurrently with the §1915(b)(1)/(b)(4) waiver, Control Number MI.0018.R02.00. Participants enrolled in MI Choice may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

RESPONSE TO IRAI 8/9/2023:

• THE HCBS ARE PROVIDED TO MEET NEEDS OF THE INDIVIDUAL THAT ARE NOT MET THROUGH THE PROVISION OF ACUTE CARE HOSPITAL SERVICES;
• THE HCBS ARE IN ADDITION TO, AND MAY NOT SUBSTITUTE FOR, THE SERVICES THE ACUTE CARE HOSPITAL IS OBLIGATED TO PROVIDE;
• THE HCBS MUST BE IDENTIFIED IN THE INDIVIDUAL'S PERSON-CENTERED SERVICE PLAN; AND
• THE HCBS WILL BE USED TO ENSURE SMOOTH TRANSITIONS BETWEEN ACUTE CARE SETTING AND COMMUNITY-BASED SETTINGS AND TO PRESERVE THE INDIVIDUAL'S FUNCTIONAL ABILITIES.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and

welfare of waiver participants in specified areas.

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met

for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

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

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

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

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

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

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

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

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

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

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

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

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for

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

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

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

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

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

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

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

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

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

Prior to writing if the renewal applications, MDHHS held six stakeholder meetings (November 2022 through January 2023) which were open to providers, waiver agencies, participants and their allies, and anyone else who chose to attend. MDHHS received feedback about aspects of the MI Choice Waiver that worked, things to be changed, and other ideas for improvements.

MDHHS issued a notification to the tribal governments on March 1, 2023, with a comment period.

MDHHS issued notification to providers and general public via electronic list servs, email, and non-electronic newspapers from May 1, 2023, through June 1, 2023. Comments were received, largely in support of the changes proposed, and some asking for clarification. Responses and clarifications have been developed and will be shared with commenters.

RESPONSES TO IRAI 8/9/2023: Draft waiver applications posted here: https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/programs/mi-choice-waiver-program.

Public comments and MDHHS responses:

Comments for which MDHHS responded Thank you for your comment:

Waiver services are proposed to expand; however, additional payment should be proposed in the proposed renewal application.

With all service expansions listed in this renewal, we would like the funding to be available to effectively deliver the service. We believe when the state implemented the non-emergency medical transportation service that funding was attached to that service. As there will not be historical data to look to for the costs of the service expansions, we would want to be prepared to cover the cost of any service expansion moving forward.

Regarding the quality withhold change, we would like to see a commitment to ongoing beneficiary engagement in determining this criteria as well as evaluating performance. However, it is difficult to comment on this proposed change to focus on improved performance rather than compliance without a full review of the criteria that will be used to evaluate performance. Conceptually it makes sense, though we'd want to be sure this does not become a way for waiver agencies currently struggling with compliance to avoid penalties for noncompliance.

We support proposed changes to authorize waiver agents to deliver assistive technology services directly.

Regarding separation of Assistive Technology from Specialized Medical Equipment and Supplies, this is an excellent change! The definition is expansive and person-centered, and it provides a great framework to allow participants to receive necessary equipment and supplies. We particularly like that the definition focuses on both the participant's function and decreasing social isolation.

Regarding allowing spouses and legally responsible individuals to provide services, we would like for spouses and legally responsible adults to be allowed to provide homemaking tasks that are for the sole benefit of the participant, or something along those lines. Or perhaps that is already possible, and these things would fall under "tasks not considered homemaking." For example, we are thinking about a situation with a participant who suffers from incontinence: would all the work around stripping, changing, and laundering sheets be excluded homemaking tasks? Those kinds of tasks could really add up, and we'd hate to see spouses/legally responsible adults not get compensated for tasks that would be paid to an outside caregiver.

For Home Delivered Meals, these are great changes. The items you're removing from the previous language will be very helpful to participants, particularly the requirement that the participant must be able to feed himself/herself. The inclusion of meal delivery kits and service/membership fees for grocery delivery services are also fantastic additions. Not only does this provide more diverse food options for participants, it also expands potential vendors for home delivered meals, which could help limit service disruption issues.

We strongly suggest that the expansion of CLS provided in hospital settings is investigated to assure that there is data to support success for HCBS for participants. We recommend that this service expansion be a pilot program with clear guidance on how and when to deliver, as well as how to approach the hospital in relation to policy, legal responsibility,

and protocols. The system should be equitable for HCBS in this scenario, as this service expansion would only apply to MI Choice participants.
In relation to offering CLS in the hospital setting, we strongly suggest gaining data to support the success of this HCBS service delivery if this has not been collected already. If there is no data to support that this measure has positive outcomes, we recommend a small pilot of this service to collect outcomes.

Regarding CLS services in the hospital, another great addition!

Regarding subsequent reassessments, "The initial iHC assessment is required to be conducted in-person. Reassessments are to be completed in-person unless the participant prefers to have the iHC completed virtually with camera on. Telephonic assessments are not allowed. If an individual is in a nursing facility that is out of service area, or transferring to a new waiver agency in a different service area, MDHHS will allow the assessment to be conducted virtually with video on." This provides nice flexibility for the participant and helps preserve some of PHE era policies that many participants may have grown accustomed to over the past few years.

Comments and responses are continued in the Additional Needed Information (Optional) section of this waiver application.

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

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

7. Contact Person(s)

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

Last Name: Coleman

First Name: Jacqueline

Title: Waiver Specialist

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

Address: P.O. Box 30479

Address 2: 400 S. Pine, 7th Floor

City: Lansing

State: **Michigan**

Zip:

48909-7979

Phone:

(517) 284-1190 **Ext:** ☐ **TTY**

Fax:

(517) 335-5007

E-mail:

ColemanJ@Michigan.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Michigan**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified

in Section 6 of the request.

Signature: Meghan Groen

State Medicaid Director or Designee

Submission Date: Nov 16, 2023

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

Last Name: Groen

First Name: Meghan

Title: Senior Deputy Director

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

Address: 400 S. Pine Street, PO Box 30479

Address 2:

City: Lansing

State: **Michigan**

Zip: 48933

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

Fax: (517) 335-5007

E-mail: GroenM2@michigan.gov

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

MDHHS requires supports coordinators to conduct the interRAI Home Care (iHC) assessment to determine applicant and participant needs related to medical conditions, service needs, financial status, among other topics. The initial iHC assessment is required to be conducted in-person. Reassessments are to be completed in-person unless the participant prefers to have the iHC completed virtually with camera on. Telephonic assessments are not allowed. If an individual is in a nursing facility that is out of service area, or transferring to a new waiver agency in a different service area, MDHHS will allow the assessment to be conducted virtually with video on. In these out of service area situations, the assessment is not complete until the individual moves and an in-person assessment is completed in the new domicile within seven days.

The iHC assessment is required initially, reassessed at 90 days after the initial assessment, then annually thereafter unless the participant has a significant change in condition.

Waiver agencies must conduct a person-centered planning meeting every 180 days to review the person-centered service plan to ensure the participant needs are still being met and update the person-centered service plan as necessary.

Waiver agency supports coordinators must obtain written or electronic consent from the participant or legal representative for any assessments or care planning meetings that are held virtually with video capability used(HIPAA compliant). The applicant or individual's privacy must be protected at all times. If the individual requires training or other assistance in using virtual methods, that training and assistance must be provided.

Included here are additional public comments and MDHHS responses continued from the Public Input section of this waiver application:

Comments for which MDHHS responded Thank you for your comment:

Critical Incident Reporting Comments: Including evictions on the list is a great addition. Evictions are incredibly stressful and potentially traumatic events, and it is great to see them acknowledged as such. One possible addition to this would be to add language about reporting eviction notices in addition to evictions. Simply going through the eviction process itself can be traumatic, even if the person ultimately is not evicted or finds alternative housing before the eviction. Including the eviction notice in the reporting process could also help prevent the eviction itself or help make the process more manageable for the participant. To that end, we would like to see an additional requirement for the waiver agency to assist the participant in preventing the eviction.

We also appreciate the more expansive and better detailed definition of Medication Errors. It is a good thing that it is not considered a medication error when an informed participant chooses to not take a medication or follow the prescribed course. That is their decision to make, and that choice did not need to be considered an error.

It would also be great to see MDHHS add reviews specific to DEI and offer targeted technical assistance to waiver agents who may need to approach participant interactions, assessments, and authorizations differently.

Regarding retention payments, this commenter strongly supports retention payments and we were excited to hear the Department is still considering adding this benefit at a later date. Not only would these payments serve as an excellent retention tool, but they could also serve as a recruiting tool. If a participant seems likely to face future hospitalizations, retention payments could provide assurance to potential providers reluctant to work with such a participant. Knowing that a participant’s hospitalization does not mean a potentially devastating interruption in pay could entice more providers to work with these participants. We understand that waiver agencies may view this as the provider getting paid to do “nothing.” We obviously do not view it that way, but perhaps there are other flexibilities that would still allow the provider to serve the participant during this period. The care provider could do things like catch up on house cleaning, laundry, and shopping while the participant is in the hospital. Or perhaps they could accompany the participant in the hospital. Anything really that would allow the provider to keep working without any interruptions.

Regarding Environmental Accessibility Adaptations, the definition includes the provision that, “The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate value.” This definition also appears in the Medicaid Provider Manual. This represents discrimination against people living in poorer neighborhoods, as the identical adaptation could be approved in a neighborhood with higher property values. We previously discussed this issue with MDHHS staff in 2020 when MI Health Link considered adding duplicate language to its waiver renewal. The provision could also result in more State spending if the result is the beneficiary moving to a nursing facility. Broadly, we believe other language already in the definition addresses the issue this provision seeks to address. For example, existing language requires the provider to install the most cost-effective modification/adaptation and there is already a prohibition on adaptations or improvements that are of

general utility but not of direct or remedial benefit to the participant. Therefore, we believe this provision is unnecessary, has unintended adverse consequences, and should be removed entirely.

Regarding presumptive functional eligibility, we would like to see an option for presumptive functional eligibility for individuals aged 18-64 who want and need MI Choice services. It seems likely that individuals who qualify for nursing home level of care will also qualify when assessed through a disability determination. We are aware of cases in which MI Choice services have been delayed for weeks or longer because of time required to obtain a disability determination. It is unfortunate that individuals age 18-64 face a potential additional impediment to the prompt provision of services.

Regarding MDHHS oversight of waiver agents, MDHHS needs the authority and capacity to impose a corrective action plan, monitor the waiver agent's compliance and impose penalties when a waiver agent's performance puts beneficiaries at risk. This could apply to broad operational issues (reports of longer than expected wait lists, refusals to put people on waitlists, inaccurate information about the number of hours a person trying to transition would get without an actual evaluation, assigning informal supports to do tasks they are unable to do in lieu of formal supports, consistently inaccurate denial notices) or individual beneficiaries who have complex and/or extensive needs and the service planning is adversarial. When an administrative appeal renders a decision that the appellant should be re-evaluated, the re-evaluation should not be done by the same waiver agent responsible for the service plan that is being appealed. The MDHHS Clinical Quality Assurance Team should be responsible for the re-evaluation and the team's decision should be binding on the waiver agent (with further appeal levels available to the beneficiary).

We suggest that the State take over the task of monitoring fiscal intermediaries, a change we believe the waiver providers would support. It would be very helpful to have an MDHHS staff person provide training and auditing for FIs especially since we understand there has been an increase in the number of entities providing this service. If the MDHHS staff person discovered systemic issues, they could be more efficiently shared and addressed than if each waiver provider was independently monitoring the FIs with whom they work.

Regarding a new competitive procurement process, we would like to see the state undergo a new competitive procurement process to select waiver agencies. It's our understanding that launching a new procurement process is not directly tied to the waiver renewal process. If it does not happen during this renewal application, we would like to see it explored in the future.

On a similar note, we would like the state to reconsider the current waiver regions, or at least develop a process to open individual counties to other waiver agencies when the current agencies cannot adequately provide services.

Comments for which MDHHS provided a more detailed response:

Comment: We appreciate that the renewal application includes service expansions. For any new service expansion (such as assisting in hospitals with care, allowing spouses to provide paid care, and other items), we would like the changes to come with an implementation plan. We are hoping the plan would include clarity of rollout, services might be staged at certain time increments for rollout, and to consider piloting in a small fashion before network rollout. We also would like pilot data to ensure successful outcomes prior to these expansions being required to rollout statewide. We want to ensure there is data available to see if the service expansion or change is impactful to those we serve.

MDHHS Response: Thank you for your comment. Additional policy and parameters will be developed and updated in the Medicaid Provider Manual. However, all participants have different circumstances, and rollout must occur on a person-centered, case-by-case basis to meet the unique needs of each MI Choice participant.

Comment: Community health workers (CHW) will be allowed as an administrative expense. The waiver renewal should authorize AAAs to directly hire CHWs if not available in the community. Other entities, including health plans, are allowed to directly hire.

MDHHS Response: MDHHS did not change the CHW service to an administrative expense. This change was not made because MDHHS did not want to jeopardize Federal Financial Participation by eliminating a service from the MI Choice waiver. Instead, MDHHS added the following language to the CHW provider qualifications "Trained waiver agency staff may be utilized if there were no other willing and qualified providers for the CHW service." Waiver agencies that cannot find qualified CHWs in the community that are willing to become a contracted network provider may ask for a provider network exception and if approved by MDHHS, hire the CHWs directly.

Comment: We appreciate that the CHW service may be allowed to be offered directly by the waiver agent under administrative expenses if there is not CHW availability in this area. We believe this service should be able to be offered by the Waiver Agents

directly with the appropriate funding following as other entities such as health plans provide to participants.

MDHHS Response: MDHHS did not change the CHW service to an administrative expense. This change was not made because MDHHS did not want to jeopardize Federal Financial Participation by eliminating a service from the MI Choice waiver. Instead, MDHHS added the following language to the CHW provider qualifications "Trained waiver agency staff may be utilized if there were no other willing and qualified providers for the CHW service." Waiver agencies that cannot find qualified CHWs in the community that are willing to become a contracted network provider may ask for a provider network exception and if approved by MDHHS, hire the CHWs directly.

Comment: The waiver renewal proposes to expand qualifications for supports coordinators to include licensed psychologists, OT, and PT in addition to social workers and registered nurses. We don't believe that those disciplines are relevant to supports coordination. MDHHS has presented this as a remedy for the workforce shortage, but these are not easy disciplines to hire. CHWs and LPNs would be more relevant to supports coordination. We don't believe that psychologists/OT/PT are viable options.
In relation to expanding who can provide Supports Coordination to include licensed psychologists, OTs and PTs, we are uncertain this will assist the workforce recruitment challenges. While we agree that broadening the approach to who may offer or support the SC service could assist with recruitment of staff and serving participants, please consider disciplines such as LPNs, Human Service degreed individuals or other counseling licensed individuals with flexibilities. Possibly allowing the RN or the LSW being the primary and the other individual being the secondary on an assessment.

MDHHS Response: MI Choice serves some of the most clinically complex and vulnerable adults at home. Licensed Practical Nurses, unlicensed individuals with Human Services degrees, and Community Health Workers do not have the qualifications to adequately address the medical and social issues faced by the population served. The service of Community Health Worker has been included in MI Choice since 2018 and is available to beneficiaries in need. Authorizing Community Health Worker services for MI Choice enrollees can help alleviate the demands on supports coordinators while assuring the enrollees have access to services and supports to meet their needs.

Comment: The proposed changes in performance measures are alarming. We request clarification regarding the proposed performance measures. We recommend restructuring quality payments to focus on improved performance rather than compliance with CQAR standards. Waiver agents strive to improve performance every day. Waiver agents will keep doing what MI Choice is known for -- person centered care. Performance guidance should be clear and streamlined to support person centered care and enhance efficiencies.

MDHHS Response: Thank you for your comment. The table in Attachment A of this document compares the current performance measures with the performance measures included in the waiver renewal application. Of the original 39 measures, 14 were unchanged, 12 were deleted, the remaining 13 measures were modified to better align with current nomenclature, federal regulations, or to use better data sources. Three performance measures were added, providing a total of 30 performance measures included in the renewal, a reduction of 23 percent in the number of performance measures.

Comment: Changes mentioned in reference to performance measures states performance measures will be focused more on improved performance, rather than compliance. With this change, we are requesting clarity and training with the performance measures themselves as a network or one to one with Waiver agents. We believe changes will be coming in relation to performance measures, restructuring quality payments, and monetary sanctions. Our agency continues to be on board with improving our performance daily. We want to keep doing what MI Choice is great at which is person centered care. We recommend that any changes to performance measures and reviews are streamlined and come with clear guidance or training prior to implementation (some efficiencies would be avoiding reporting the same information to multiple entities, having one consistent reviewer per agency, accreditations and other measures of quality are used to measure success).

MDHHS Response: Thank you for your comment. MDHHS will keep waiver agencies informed of requirements and expectations.

Comment: Can a spouse or legally responsible adult be hired through an agency via Agency with Choice? Or are they barred as caregivers no matter the self-determination arrangement?

MDHHS Response: A spouse or legally responsible adult may be hired through a network provider agency through a traditional arrangement, but not through a self-determined arrangement such as Agency with Choice. As stated in the Community Living Supports service definition: "Spouses and legally responsible adults are allowed to be paid caregivers in limited situations. They must not be hired via the self-determination arrangements. These individuals must be hired by a home care agency that will

provide supervision and oversight to ensure services are being delivered."

Comment: The new language states: "Spouses and legally responsible adults are allowed to be paid caregivers in limited situations." Is there any additional guidance regarding what those "limited situations" are?

MDHHS Response: Thank you for your comment. Yes, additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: Spouses and legally responsible individuals are authorized to provide CLS in limited situations. Will funding follow this enhancement?

MDHHS Response: Because MI Choice is a managed care program, all rates developed must follow the actuarially sound requirements specified by CMS. Allowing spouses to be paid caregivers in and of itself may not warrant a change in funding since some of these services may currently be provided by other paid caregivers and the costs are already included in the capitation rates.

Comment: Waiver agents request clarity around deciding between formal and informal care in these instances. What does limited situations mean?

MDHHS Response: Thank you for your comment. Additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: While we agree with expanding food services such as grocery delivery, we are uncertain of the impact of "meal kit" on those we serve. While this was allowed during the PHE, we believe it was minimally used during the pandemic. The expansion of grocery delivery is a more viable flexibility to meet the nutritional needs of participants.
We also appreciate the specific flexibilities offered for nutrition. We would recommend grocery delivery as the more viable service expansion than meal kits. We do not believe meal kits would be an ideal service for our participants. We believe current services with the addition of grocery delivery would contribute meeting the adequate nutritional needs of our participants.

MDHHS Response: Thank you for your comment. Based on participant feedback, MDHHS has chosen to allow meal kits and payment of grocery delivery service fees to offer more options to participants.

Comment: The proposed language looks good, though it may be helpful to include something that flags that the a-f list of circumstances is not an exhaustive list of situations where CLS could be provided in the hospital. The use of the word "may" in "Examples of the circumstances for which this could be allowed may be:" seems to make it clear that this is not an exhaustive list. However, many of the waiver agency staff in the waiver renewal stakeholder meetings expressed concern with the idea of providing CLS in hospitals in any capacity, and we worry that they might see this list and read the language as "Examples of the circumstances for which CLS is allowed are:." A simple sentence such as "The examples provided below/above are not an exhaustive list of circumstances in which CLS can be provided to participants while in the hospital" would address this issue.

MDHHS Response: Thank you for your comment. MDHHS will add that language.

Comment: Can there be clarification on how and when a video assessment can be done (assuming it is the participant's request). Both in a single SC approach and a team approach.

MDHHS Response: Thank you for your comment. Additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: Also, if a situation warrants a RN/SW approach for an existing participant, can this assessment be completed with 1 clinical SC being in person and the other clinical SC via video call remotely? Also, if a situation warrants a RN/SW approach and If the participant requests an in-person assessment, can the primary complete in person and the secondary SC complete the assessment via video?

MDHHS Response: Thank you for your comment. Additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: Regarding separation of Residential Services from Community Living Supports, the proposed language reads: Residential Services are defined as: Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a setting that meets the home and community-based setting

requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the assisted living provider. Comments: CLS cannot be provided in residential settings such as Adult Foster Care, Homes for the Aged, or other assisted living facilities. Residential services must be used instead. Considering this, is the definition of Residential Services sufficient to cover all necessary services? For example, CLS includes Dementia care, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan. Does the Residential Services definition allow for comparable services?

MDHHS Response: Yes, the residential services definition allows for comparable services.

Comment: Could a participant potentially receive both Residential Services and CLS during "social and recreational programming" services that occur outside the facility?

MDHHS Response: Yes, this is permissible.

Comment: Regarding the diversity, equity, and inclusion training, adding DEI training requirements is wonderful. And while we don't want MDHHS to have to identify a specific DEI training for waiver agents to complete, it would be nice to see some kind of standard attached to this. We all know there can be great trainings and there can be terrible trainings, and we would hate for these DEI trainings not to have their intended effect because waiver agencies satisfied the requirement with lackluster or ineffective options. Perhaps requiring that these be evidenced-based DEI trainings or something along those lines would help ensure these trainings are effective.

MDHHS Response: Thank you for your comment. MDHHS agrees that DEI training must be effective. However, MDHHS is does not advocate a specific training, especially not within the waiver application. Were a specific training to be required, then become unavailable in the next five years, MDHHS would need to amend the waiver application. It is better to be generic in this requirement within the waiver application.

Comment: What remedies exist when, for example, members of a specific community are not actually receiving services? It would be helpful to be able to utilize something like the Special Focus Facility designation that LARA uses for particularly troubled nursing homes to address these gaps in care for a specific waiver provider. If the model were similar to the Special Focus Facility designation, it would trigger more frequent oversight of the waiver agent, a public listing of the name of the troubled provider and how long it has been designated as a problem provider, and requirements that the waiver provider improve within a specific amount of time. When a waiver provider or agency has been designated or designation is being considered, the Department should explore:
a. How does this region or waiver agency compare to other regions in the state? Can we identify the unique problems that exist in this region that led to gaps in services?
b. Can the state eventually impose civil monetary penalties?

MDHHS Response: Thank you for your comment. CMS is requiring more scrutiny of managed care entity's provider networks. This additional scrutiny may address these concerns.

Comment: President Biden and a number of states are pursuing measures to assure more transparency and accountability from the nursing home industry and this effort has received a great deal of public attention. We should demand the same from HCBS providers. Among the information that should be available to the state and the public are:
- Payment rates to home care provider agencies?
- What do waiver agents pay to agencies and SD workers.
- Caseload statistics that will demonstrate which agencies have high caseloads. While we recognize that different providers have different staffing structures, there may be a way to both share more information and control for the different staffing arrangements.
- The number of individuals who are actually being served, broken down county by county, with data that distinguishes between authorized and utilized hours. If a waiver provider is not serving anyone in Washtenaw County, for example, because of a lack of caregivers, no individuals will be served until a new provider network is established even if hours of service have been authorized.

MDHHS Response: Thank you for your comment. CMS is requiring more scrutiny of managed care entity's provider networks. This additional scrutiny may address these concerns.

Comment: Regarding the network adequacy and provider pool, currently, two waiver agents operating in the same service area

can both cite the same providers when establishing the adequacy of their provider pool. Because both waiver agents serve separate groups of beneficiaries, this practice overstates the adequacy of the provider pool. MDHHS should use a process that compares the total number of beneficiaries served in the service area to the provider pool for that service area to determine if both waiver agents have adequate networks to serve all of their participants.

MDHHS Response: Thank you for your comment. CMS is requiring more scrutiny of managed care entity's provider networks. This additional scrutiny may address these concerns.

Comment: The shortage of direct care workers, nurses and social workers compromises the waiver agents' ability to meet its contractual obligations and puts beneficiaries at risk. The waiver agents can spend more on staffing and those investments may be reflected in future PMPM rate increases. However, this option is wholly inadequate to address the growing worker crises in health care. MDHHS should modify the rate setting process to allow for immediate funding of compensation increases substantial enough to attract and retain workers in all essential roles.

MDHHS Response: Thank you for your comment. CMS has very complex and comprehensive rules and regulations for setting actuarily sound capitation rates for all managed care programs which MDHHS follows.

Comment: The new Ensuring Access to Medicaid Services proposed rule (CMS 2442-P) to the federal HCBS waiver requirements contains several items of great interest to advocates. These are still proposed rules, but it would be fantastic if the state would consider collecting this data now.
- In particular, there are two specific reporting requirements that would provide important data on services in the home. This data could help identify gaps in approved services vs. actual services provided, as well as gaps in care caused by shortages in the direct care workforce.

- The new proposed regulation at 42 CFR § 441.311(d)(2)(i) would require the state to report the average amount of time from when homemaker services, home health aide services, or personal care services are initially approved to when services begin for individuals newly approved to begin receiving services. The proposed regulation at 42 CFR § 441.311(d)(2)(ii) would require the state to report the percent of authorized hours for homemaker services, home health aide services, or personal care services that were actually provided within the past 12 months.

- Both of these regulations would identify when the waiver agency is not providing services, and if the data is reviewed on a rolling basis it could help pinpoint providers/regions that are struggling most.

MDHHS Response: Thank you for your comment. MDHHS is well aware of the proposed rules and when finalized will follow CMS guidance on adhering to the rules.

RESPONSES TO IRAI 8/9/2023:
THERE WERE A FEW CHANGES MADE TO COST EFFECTIVENESS AND COST NEUTRALITY FIGURES AFTER UPDATES WERE MADE BY THE ACTUARY DUE TO ADDING ANOTHER QUARTER OF DATA (JANUARY-MARCH 2023).
APPENDIX J CHANGES:
- J-1 – The Factor D costs have increased slightly based on the use of updated experience. No changes were reflected in the Factor D', G or G', values. While this adjusted the values in Column 8 (D+D' minus G+G'), the cost neutrality of the waiver is not materially impacted.
- J-2-d – Values for all years and services have been adjusted slightly based on the additional quarter of experience.

1915b CHANGES FOR COST EFFECTIVENESS:
• D1. Member Months – Additional quarter reflected in R2 and updated member month projections based on additional data
• D2. A Admin in Waiver Cost – Doubled the aggregate amount of state administrative amounts for R2 based on additional quarter.
• D3. Actual Waiver Cost – Updated experience resulted in slightly lower R2 PMPMs.
• D4. Adjustments in Projection – Included a reference to the 1915(c) cost adjustment due to the coverage expansion.
• D5. Waiver Cost Projections - Included columns AB and AC to reflect the expansion of services as shared by MDHHS
• D6. RO Targets – Adjustments from prior worksheets flow through to this tab.
• D7. Summary – Adjustments from prior worksheets flow through to this tab and have included the currently approved waiver period 4 and 5 costs for the cost effectiveness comparison
Please note that due to the update for R2 experience, the most recent waiver period is under the cost effectiveness benchmark.

1915b CHANGES TO COST EFFECTIVENESS IN RESPONSE TO RAI:

• D2. S Services in Waiver Cost – We have added Vehicle Modifications and Supports Brokerage to the list of services
• D5. Waiver Cost Projections –
  o Removed the projected inflation adjustment of 4% for P1 to acknowledge that the capitation rate change is now known
  o Included a 12.5% adjustment to the capitation rates (and associated incentive/withhold) to reflect the increases applied to the MI Choice capitation rates at October 1, 2023.
• D6. RO Targets – Adjustments from prior worksheets flow through to this tab
• D7. Summary – Adjustments from prior worksheets flow through to this tab

Appendix A: Waiver Administration and Operation

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

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

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

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

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

RESPONSES TO IRAI 8/9/2023:
The contracted entities for the MI Choice program are Prepaid Ambulatory Health Plans (PAHPs). Some are area agencies on aging, and some are other community-based organizations. These entities perform participant waiver enrollment, waiver enrollment managed against approved limits, assess for level of care and provide information to MDHHS and MDHHS makes the final decision about level of care, review of participant service plans, prior authorization of waiver services, utilization management, qualified provider enrollment, execution of Medicaid provider agreements.

Michigan Public Health Institute (MPHI) perform quality assurance and quality improvement activities. MPHI conducts clinical retrospective reviews of service person-centered service plans and other activities performed by PAHPs.

Health Services Advisory Group (HSAG) perform quality assurance and quality improvement activities and provide feedback to facilitate improvement.

Milliman, the actuary, establishes statewide rate methodology.

iMPROve Health conducts reviews of level of care evaluations.

Michigan State University conducts the CAHPS survey

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local

or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

The Home and Community Based Services Section (HCBSS), organizationally situated in the Aging and Community Services Division, Bureau of Aging, Community Living and Support, in the Behavioral and Physical Health and Aging Services Administration, under the Michigan Department of Health and Human Services, is responsible for assessing the performance of each waiver agency.

ADDED IN RESPONSE TO IRAI 8/9/2023:
Michigan Public Health Institute (MPHI) perform quality assurance and quality improvement activities. MPHI conducts clinical retrospective reviews of service person-centered service plans and other activities performed by PAHPs.

Health Services Advisory Group (HSAG) perform quality assurance and quality improvement activities and provide feedback to facilitate improvement.

Appendix A: Waiver Administration and Operation

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

MDHHS uses several methods to assess the performance of waiver agencies and assure assigned operational and administrative functions are completed in accordance with waiver requirements. MDHHS examines administrative elements during the Administrative Quality Assurance Reviews (AQAR) MDHHS contracts with an External quality Review Organization (EQRO) to examine the case record elements during the Clinical Quality Assurance Reviews (CQARs). MDHHS contracts with a third party vendor to conduct participant satisfaction surveys and provide analysis of the results.

The AQAR process includes an examination of policy and procedure manuals, provider monitoring reports, provider contract templates, financial systems, encounter data accuracy, quality assurance and performance improvement plans (QAPI) and verification of required provider licensure to assure that each waiver agency meets all requirements. The AQAR also verifies the waiver agency meets administrative, program policy, and procedural requirements by ensuring maintenance of program records for ten years, controlled access to program records according to HIPAA requirements, waiver agency employee access to program policies and procedures, and proper accounting procedures. MDHHS reviews waiver agency agreements with subcontracted providers, performs provider reviews, and may conduct interviews with both supports coordinators and MI Choice participants. The AQAR is completed for each waiver agency once every five years unless significant issues are discovered. The frequency is based on AQAR scores (percentage of compliance):
86-100 percent, reviewed every five years
80-85 percent, reviewed every four years
70-79 percent, reviewed every three years
Less than 70 percent, reviewed every two years

The second element is the CQAR. The EQRO employs qualified reviewers to complete the CQAR for every waiver agency each fiscal year. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each participant. The CQAR includes a review of whether person-centered service plans and service delivery are in compliance with State and Federal requirements. Identified discrepancies are reviewed and addressed.

MDHHS monitors implementation of the concurrent §1915(b)/(c) MI Choice waivers and monitors the following waiver agency delegated responsibilities:

Participant Waiver Enrollment – MI Choice has three requirements for program eligibility: 1) medical/functional (nursing facility level of care), 2) financial (Medicaid eligible), and 3) the need for at least one MI Choice service in addition to Supports Coordination. Waiver agencies assess medical/functional eligibility during face-to-face interview using the Nursing Facility Level of Care determination (LOCD) tool, or otherwise known as NFLOC. MDHHS requires waiver agencies to put NFLOC results for all enrollments in the State's NFLOC system. The NFLOC system determines whether an individual meets NFLOC. The State's MMIS system will not approve MI Choice capitation payments for persons who do not have a valid, passing NFLOC in the system. MDHHS requires the EQRO to monitor compliance with NFLOC policy during annual CQARs by reviewing NFLOC determinations against completed iHC assessments. The CQAR process assures participants continually meet NFLOC criteria throughout MI Choice enrollment. MDHHS uses additional methods to validate the level of care determinations in the NFLOC system.

MDHHS local office staff determines financial eligibility for potential MI Choice participants. When the MDHHS local office affirms program financial eligibility, the waiver agency enters an enrollment record into the State's MMIS system. A Benefit Plan and Program Enrollment Type for MI Choice will be automatically assigned in the MMIS system. The system contains payment edits that will generate MI Choice capitation payments only when the beneficiary’s record contains both the MI Choice Benefit Plan and Program Enrollment Type.

MDHHS requires waiver agencies to monitor their caseload for participants who have not received services for 30 days. This is a quality measure required in the QAPI. Persons who do not require a MI Choice service are removed from the program following established policies and procedures.

Waiver Enrollment Management Against Approved Limits - Waiver agencies manage applicant enrollment into MI Choice and must develop written procedures for enrollment activities that are consistent with MDHHS policy. MDHHS reviews these policies and procedures during the AQAR, or when waiver agencies propose changes to their policies and procedures. MDHHS monitors enrollment counts on a monthly basis. MDHHS monitors nursing facility transition requests and activities as they occur.

Waiver Expenditures Managed Against Approved Levels – Waiver agencies maintain administrative and financial accountability and manage expenditures against approved levels. The waiver agencies must take full advantage of services in the community that are paid for by other sources before authorizing MI Choice services for a participant. MDHHS routinely monitors encounters, expenditures, and administrative data from the Medicaid data warehouse. MDHHS also conducts reviews of expenditures and financial policies and procedures during the AQAR.

MDHHS also reviews LOCD administrative hearing decision summaries regularly, provides technical assistance and training, and initiates corrective actions as needed. MDHHS reviews all determinations and provides final approval as well as final decisions on denials and terminations for the MI Choice program.

Reviews of Participant Person-Centered Service Plans – Waiver agencies work with each participant and their allies to develop a written person-centered service plan. During the CQAR process, the EQRO conducts annual service plan and case record reviews on a statistically significant random sample of participants to ensure adherence to MDHHS contract and policy requirements. Reviews include ensuring services are provided as planned, person-centered planning is used, and services and supports are consistent with identified needs and preferences.

Prior Authorization of Waiver Services – Waiver agencies use person-centered planning (PCP) principles to develop a person-centered service plan with the participant. The participant must approve of all services in the person-centered service plan before the waiver agency may authorize the participant's chosen qualified provider to start furnishing the services. During the CQAR review process, the EQRO confirms participant approval and assures the approval occurred before services started. As part of the AQAR process, MDHHS verifies the waiver agency has policies and procedures related to the person-centered service plan development and that those policies and procedures are consistent with MDHHS and Federal requirements.

Utilization Management – Waiver agencies determine the appropriateness and efficacy of services provided. As part of the AQAR process, MDHHS conducts financial reviews by evaluating a sample of participants' claims to the services included on the person-centered service plan over a three month period. This process includes reviewing the service record from inception through approved Medicaid encounter data to verify records match by date of service, amount, duration, and type of service. During CQAR reviews, the person-centered service plan is compared to iHC data and other information available in the record to assure the person-centered service plan meets the participants identified needs.

Qualified Provider Enrollment - Waiver agencies approve and enroll qualified service providers in their provider network to furnish MI Choice services. MDHHS requires each waiver agency to have an open bid process and to enroll willing and qualified providers in their provider network. MDHHS reviews and approves the contracting process and bid packet used by each waiver agency. MDHHS requires each waiver agency to have a provider network with capacity to serve at least 125% of their expected utilization for each MI Choice service and at least two providers for each MI Choice service. This assures network capacity as well as choice of providers. When waiver agencies cannot assure this choice within 30 miles or 30 minutes of travel time for each participant, they may request a rural area exception from MDHHS.

Waiver agencies must have policies and procedures that describe the frequency and method of verifying and monitoring staff qualifications. MDHHS reviews these policies and procedures during the AQAR process, or sooner if the waiver agency makes changes. MDHHS requires waiver agencies to submit provider network reports within 60 days of the start of the fiscal year that list all of their contracted providers, the services offered by each, and their capacity to serve MI Choice participants. Updates to this listing must be sent within 30 days of any changes. In addition to monitoring qualifications during the annual contracting process, MDHHS requires waiver agencies to complete a comprehensive provider monitoring on 20% of providers annually. Waiver agencies use a monitoring tool created by MDHHS during their provider monitoring. At the beginning of the fiscal year, MDHHS requires waiver agencies to send provider monitoring schedules to MDHHS. The waiver agency submits provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. MDHHS reviews and evaluates these reports for completeness and integrity of the process and may request additional information if there are any concerns. MDHHS will contact other waiver agencies using a provider if significant deficiencies are found. MDHHS also reviews provider files during AQAR. Additionally, waiver agencies are required to conduct provider monitoring for 100 percent of provider owned and controlled residential settings as well as non-residential Adult Day Health settings to ensure compliance with federal regulations.

Execution of Medicaid Provider Agreements – Waiver agencies use the Medicaid Provider Enrollment Agreement to complete enrollment into the waiver agency's provider network. The waiver agencies maintain signed and executed agreements on file. MDHHS reviews waiver agency agreements with subcontracted providers during the AQAR and as

described above. MDHHS requires that Community Living Support and Respite providers must be enrolled in the MMIS system (CHAMPS) to ensure appropriate background screening is completed. Once CHAMPS is ready to accept provider enrollment for atypical providers, they must all be enrolled in CHAMPS in order to receive payment for services. Until CHAMPS is ready to accept atypical provider enrollment, the waiver agencies retain the responsibility to assure criminal history screenings are conducted for their service providers.

Quality Assurance and Quality Improvement Activities – Waiver agencies develop their own QAPIs biennially that address CMS and MDHHS quality requirements. MDHHS reviews and analyzes waiver agency QAPIs and the associated yearly update reports. These reports provide detail regarding progress in quality assurance and quality improvement activities. MDHHS also compiles and compares individual waiver agency quality indicators and statewide averages. MDHHS has the capacity to run data on quality indicators and examine it at any time to monitor each waiver agency's performance as needed.

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver agencies who submit annual Quality Assurance and Performance Improvement (QAPI) activity and outcome reports that illustrate they are adhering to their QAPI. Numerator: Number of waiver agencies that submit annual QAPI activity and outcome reports that illustrate adherence to their QAPI. Denominator: All waiver agencies.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of performance improvement projects that showed improvement.
Numerator: Number of performance improvement projects that showed improvement.
Denominator: Number of performance improvement projects by waiver agency.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Performance improvement projects submitted by waiver agencies

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures. Numerator: Number of qualified participants enrolled consistent with policies and procedures. Denominator: All participant files reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of person-centered service plans that were completed and approved by the participant within 90 days of an assessment. Numerator: Number of person-centered service plans that were completed and approved by the participant within 90 days of an assessment. Denominator: Number of service plans reviewed.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

MDHHS conducts the following monitoring processes in addition to the quality assurance reviews:

1. Routinely monitors encounter and capitation data from the Medicaid data warehouse.
2. Verifies active licensure via a public website for each licensed employee conducting MI Choice business at the waiver agency annually or sooner if the waiver agency provides an updated personnel list.
3. Routinely reviews, analyzes, and compiles all MI Choice administrative hearings and appeals decisions and takes corrective action when a waiver agency is non-compliant with a decision and order resulting from an administrative hearing.
4. As needed, investigates and monitors through resolution complaints received regarding operations of the MI Choice waiver program. This process might involve discussion with the waiver agency, participants or their representatives, MDHHS, or any other entity that might be helpful in producing a resolution.
5. Routinely monitors, reviews, and evaluates the Critical Incident Reporting System.

In addition, MDHHS performs the following functions:

a. MDHHS verifies sub-contracted providers have active licenses as required and meet provider qualifications.

MDHHS approves the contracting process used by each waiver agency. This includes confirming providers have active licenses (all licensing information is available online) and meet all qualification requirements. MDHHS reviews and approves the bid packet as necessary. MDHHS reviews each agency's policies and procedures and contractor files during the AQAR. When MDHHS has concerns about any provider, it may look up provider licenses online at any time. MDHHS requires the following providers of MI Choice services to be licensed: supports coordinators; nurses (RN or LPN) furnishing private duty nursing or nursing services; respiratory therapists if used for respiratory care; adult foster care homes, and homes for the aged. MDHHS conducts a 100% license verification process for all supports coordinators annually, and as additional staff are reported to MDHHS.

b. MDHHS provides administrative oversight of provider approvals, sanctions, suspensions, and terminations by the waiver agencies.

As part of the contract between MDHHS and the waiver agencies, MDHHS outlines steps waiver agencies can require as part of provider corrective action plans. As stated previously, waiver agencies send all provider monitoring reports, including corrective action plans, to MDHHS. MDHHS reviews these reports and may request additional information.

b. Methods for Remediation/Fixing Individual Problems

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

If any participant is found to be enrolled and is being served but does not qualify for the program, the waiver agency must help the participant find alternative services in the community. The waiver agency must start disenrollment procedures with the participant within seven days of notification of the finding and must also inform the participant of appeal rights. MDHHS will recover all Medicaid capitation payments made during the period of ineligibility.

If any person-centered service plans (PCSP) for participants are not completed in the required time frame, the waiver agency must develop a PCSP within seven business days of the finding.

If any PCSPs do not support paid services, the waiver agency either must immediately (within seven business days) update the PCSP as necessary and have the participant review and provide approval, or arrange for the appropriate level of services to be provided as specified in the PCSP.

All waiver agencies submit a quality assurance and performance improvement (QAPI) every two years and an Activity and Outcome report annually to MDHHS. The Activity and Outcome report provides an update on progress made towards the QAPI. If an Activity and Outcome report that does not illustrate that the waiver agency is adhering to its QAPI, the waiver agency must submit a revised Activity and Outcome report that addresses all of the plans in the approved QAPI. The waiver agency may be required to revise and resubmit its QAPI within two weeks of the finding.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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

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

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

Specify:

Participants in the MI Choice program who are eligible due to a physical disability and reach age 65 are then deemed to have continued program eligibility by virtue of their age. No transition is necessary within the program.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the

number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	18734
Year 2	20171
Year 3	20543
Year 4	20915
Year 5	21287

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	13400
Year 2	13600
Year 3	13900
Year 4	14100
Year 5	14300

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served

subject to a phase-in or phase-out schedule *(select one)*:

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

e. Allocation of Waiver Capacity.

Select one:

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

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

(a) Michigan operates its waiver through waiver agencies.

(b) The methodology used to allocate capacity is based on several factors:

1. Original allocation was determined by demand for services when the waiver began operation.
2. Annual allocations are determined by the funds approved in the final State budget.
3. Waiver agencies are allocated additional slots based upon the following factors (in no particular order of importance):
   a. Each waiver agency's previous percentage of the statewide allocation
   b. The number of participants currently enrolled at the waiver agency
   c. The number of individuals on the waiting list in a provider service area relative to the number of waiver participants in the provider service area
   d. The number of unused slots in the previous fiscal year for each waiver agency
   e. The average number of days individuals are on the waiting list for each provider service area (i.e. wait time)

MDHHS uses an algorithm for reallocating slots each fiscal year. The algorithm accounts for the available funding, the current number of slots filled (i.e. carry over from one fiscal year to the next), each waiver agency's capacity to fill slots, the number of individuals on the waiting list, and the average length of time on the waiting list before enrollment. Agencies that have used previously allocated slots and have a high number of individuals on the waiting list, and a longer wait time are allocated more slots each year than other agencies.

(c) There is currently no excess capacity in any of the waiver agencies. MDHHS may not use all requested slots per year, but it does deplete allocated program funding each fiscal year. The Michigan Legislature allocates a specific amount of funding each year for the MI Choice program. MDHHS can only allocate slots up to the amount determined to deplete that funding. There is a waiting list for MI Choice services.

RESPONSE TO IRAI 8/9/2023: THE STATE'S PRACTICES DO NOT VIOLATE THE REQUIREMENT THAT INDIVIDUALS HAVE COMPARABLE ACCESS TO WAIVER SERVICES ACROSS THE GEOGRAPHIC AREAS SERVED BY THE WAIVER OR IMPEDE THE MOVEMENT OF PARTICIPANTS ACROSS GEOGRAPHIC AREAS.

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

All applicants for MI Choice must meet nursing facility level of care requirements as ASSESSED by a qualified professional through an evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD), herein also referred to as NFLOC. DATA FROM THE ASSESSMENT IS ENTERED IN TO THE STATE'S CHAMPS SYSTEM AND CHAMPS MAKES THE LEVEL OF CARE DETERMINATION. After this evaluation, MDHHS requires that individuals receive information on all programs for which they qualify. Individuals then indicate the program of their choice and document the receipt of information regarding their options by completing the Michigan Freedom of Choice form. This form must be signed and dated by the applicant seeking services or their legal representative, indicate the individual chooses to receive services through the MI Choice program, and is maintained in the applicant's case record.

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

1. Young adults who are no longer eligible for State Plan Private Duty Nursing Services because of age restrictions on this benefit who continue to demonstrate a need for Private Duty Nursing services;

2. Nursing facility residents who meet program requirements, and express a desire to return to a home and community based setting;

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

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

Category 1 has the highest priority and individuals on the waiting list in this category are enrolled first. Then, applicants in Category 2 followed by applicants in Category 3 followed by applicants in Category 4 are enrolled. Within each category applicants are prioritized in chronological order by date of inquiry. However, because of unique circumstances pertaining to each applicant, actual enrollment may vary from the waiting list ranking of an individual. For instance, some applicants in category 2 may need to wait to enroll in MI Choice until they secure affordable housing. This would not prevent an applicant who was lower on the waiting list and ready to enroll from doing so, as long as there are slots available. All waiting list priority categories are established and further defined in state Medicaid policy.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- (●) **No**
- ( ) **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

◉ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

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

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

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

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

  Specify the entity:

- ( ) **Other**
  Specify:

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

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health care professional: physician, registered nurse, licensed practical nurse, limited licensed social worker (BSW or MSW), licensed social worker (BSW or MSW), licensed psychologist, physician assistant, nurse practitioner, respiratory therapist, physical therapist, occupational therapist, or speech therapist.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Enrollment into the MI Choice waiver requires the applicant to meet the State Medicaid Agency's specified medical/functional eligibility criteria for nursing facility level of care using the Nursing Facility Level of Care Determination (LOCD) Tool. Waiver agencies conduct the evaluations, but the State provides the final approval or denial for all LOCDs. Nursing facility level of care criteria consists of EIGHT (RESPONSE TO IRAI 8/9/2023) medical/functional domains that are outlined in the LOCD Tool. These domains, or doors, are: Door 1: Activities of Daily Living, Door 2: Cognitive Performance, Door 3: Physician Involvement, Door 4: Treatments and Conditions, Door 5: Skilled Rehabilitation Therapies, Door 6: Behavioral Challenges, Door 7: Service Dependency, and Door 8: Frailty Criteria. The applicant must meet, and continue to meet, the LOCD criteria on an on-going basis to remain eligible for the program. The online LOCD is completed every 365 days for each participant, unless the participant has a significant change of condition which may change their current eligibility status. The online NFLOC/LOCD system determines whether the applicant/participant meets or does not meet level of care.

Door 1 - Activities of Daily Living (ADL) Dependency

Self-ability in (A) Bed (sleeping surface) Mobility, (B) Transfers, and (C) Toilet Use in the last seven (7) calendar days from the date the LOCD was conducted online:

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

Self-ability in (D) Eating in the last seven calendar days from the date the LOCD was conducted online:

Independent or Supervision = 1
Limited Assistance = 2
Extensive Assistance or Total Dependence = 3
Activity Did Not Occur during the entire 7-day period regardless of ability (applicant did not eat) = 8

Door 1 Eligibility Requirement: The applicant must score at least six points in Door 1 to qualify.

Door 2 - Cognitive Performance

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

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

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

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

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

conversation.

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

Door 2 Eligibility Requirement: The applicant must score under one of the following three options:

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

Door 3 - Physician Involvement

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

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

Door 3 Eligibility Requirement:

1. Over the last 14 calendar days, at least one day in which the Physician visited and examined the applicant AND at least four days in which the Physician changed orders, OR
2. Over the last 14 calendar days, at least two days in which the Physician visited and examined the applicant AND at least two days in which the Physician changed orders.

Door 4 - Treatments and Conditions

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

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

Door 4 Eligibility Requirement: The applicant must score 'Yes' in at least one of the nine categories AND have a continuing need.

Door 5 - Skilled Rehabilitation Therapies

Skilled rehabilitation interventions is based on ordered AND scheduled therapy services within the last seven (7) calendar days from the date the LOCD was conducted online.

A. Speech Therapy in the last seven (7) calendar days
B. Occupational Therapy in the last seven (7) calendar days
C. Physical Therapy in the last seven (7) calendar days

Minutes: record the total minutes speech, occupational and physical therapy was administered for at least 15 minutes a day. Do not include evaluation minutes. Zero minutes are recorded if less than 15.

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

Door 5 Eligibility Requirements: The applicant must have required at least 45 minutes of active speech therapy, occupational therapy, or physical therapy (scheduled or delivered) in the last seven (7) calendar days AND continue to require skilled rehabilitation therapies to qualify.

Door 6 – Behavior

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

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

Door 6 Eligibility Requirement: The applicant must have exhibited any one of the above behavioral symptoms in at least four of the last seven (7) calendar days (including daily) from the date the LOCD was conducted online OR the applicant exhibited delusional thinking or clearly demonstrated having experienced hallucinations within seven (7) calendar days from the date the LOCD was conducted online AND met the PASARR requirement for nursing facility admission if they choose a residential setting of care.

Door 7 - Service Dependency

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

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

provider can provide those services/needs)

Door 7 Eligibility Requirement: The applicant must meet all three of the above criteria to be determined service dependent.

Door 8: Frailty Criteria, must meet one of the criteria for eligibility.
Frailty: 6 criteria
1. performs late loss ADLs independently but requires unreasonable amount of time
2. performance in activities impacted by shortness of breath, pain or weakness
3. at least two falls in the past month
4. difficulty managing medications
5. poor nutrition despite meal preparation services
6. ER visits for unstable conditions

Behaviors:
1. wandering
2. verbal/physical abuse
3. socially inappropriate behavior
4. resists care

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

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

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

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

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

An LOCD must be conducted according to MDHHS policy prior to MI Choice enrollment for every MI Choice participant. The LOCD must be entered in the online system no more than fourteen (14) calendar days from the conducted date. The LOCD may be entered at any time prior to enrollment as long as it remains valid upon enrollment. A valid LOCD is an LOCD that has been entered into the NFLOC/LOCD system and demonstrates the individual meets the nursing facility level of care. Annual LOCD reevaluations are conducted by qualified individuals according to MDHHS policy and are entered into the State's online NFLOC/LOCD system. The LOCD is required to be conducted every 365 days or sooner if there is a significant change in condition. The online NFLOC/LOCD system determines whether the applicant/participant meets or does not meet nursing facility level of care.

RESPONSES TO IRAI 8/9/2023:
The Michigan Medicaid Nursing Facility Level of Care Determination must be completed by a health care professional: physician, registered nurse, licensed practical nurse, limited licensed social worker (BSW or MSW), licensed social worker (BSW or MSW), licensed psychologist, physician assistant, nurse practitioner, respiratory therapist, physical therapist, occupational therapist, or speech therapist.

The criteria is the same for evaluations and reevaluations.

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

MDHHS uses a two-tiered quality assurance strategy to verify the quality of all level of care determinations conducted within the state. The first tier is a statewide process used for nursing facilities, MI Health Link, PACE, and MI Choice. MDHHS requires ALL nursing facility level of care determinations conducted for individuals who are either applying or currently served by a long-term care program to be put in a secure web-based system that is located within the Community Health Automated Medicaid Processing System (CHAMPS), Michigan’s Medicaid Management Information System. Licensed, qualified health professionals conduct the nursing facility level of care determination using the statewide tool available on the Michigan Nursing Facility Level of Care Determination webpage and input their findings into the software application within CHAMPS. CHAMPS then runs the data through the nursing facility level of care algorithm to determine whether an individual meets the nursing facility level of care.

The quality assurance for this first tier is to randomly select at least 400 records that meet the nursing facility level of care and 400 records that do not meet the nursing facility level of care for additional review. MDHHS contracts with an external organization to conduct reviews of the selected records to verify the level of care determination was properly conducted by the health professional.

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

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

For this first tier of quality assurance, MDHHS uses the simple random sampling technique. This technique is needed for several reasons. First, the nursing facility level of care determination is required to be completed BEFORE the individual is enrolled in a HCBS program. Second, individuals often require this determination BEFORE they can become eligible

for Medicaid-funded LTSS. Lastly, individuals commonly transfer between HCBS programs and nursing facilities. Therefore, stratification of this sample based upon the program utilized by the individual at the time of the determination is impossible.

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

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

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

Specify the other schedule:

A reevaluation is required every 365 days or with significant change in condition.

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

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

Specify the qualifications:

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

The state requires supports coordinators to reevaluate each MI Choice participant's level of care at each in-person reassessment visit. The supports coordinators document that the participant continues to meet the nursing facility level of care within the case record, usually specifying the appropriate "door" through which the participant meets level of care criteria. Reassessments are conducted in person 90 days after the initial assessment, with a reassessment annually, or upon a significant change in the participant's condition. Supports coordinators track reassessment dates within the waiver agencies' information systems. When a supports coordinator suspects the participant no longer meets the nursing facility level of care, the supports coordinator conducts a new LOCD and enters the information in the State's NFLOC/LOCD system, which makes the level of care eligibility determination. When the system confirms the participant no longer meets nursing facility level of care, the supports coordinator initiates program discharge procedures and provides the participant with the adverse benefit determination and information on appeal rights.

The EQRO monitors compliance to this requirement during the clinical quality assurance reviews.

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

The NFLOC/LOCD system maintains all level of care determinations for a minimum of 10 years. Waiver agency case records must confirm participants continue to meet LOCD criteria during MI Choice enrollments. This may be accomplished by verifying online LOCD records for participants, maintaining paper copies of LOCDs for participants, or identifying assessment data that supports LOCD eligibility within the record.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants who had level of care determinations where the level of care criteria was accurately applied. Numerator: Number of participants who had level of care determinations where the level of care criteria was accurately applied. Denominator: Number of participant files reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

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

Specify: EQRO		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of appropriate LOC determinations found after MDHHS review. Numerator: Number of appropriate LOC determinations found after MDHHS review. Denominator: Number of LOC determinations reviewed by MDHHS.

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

State's NFLOC determination system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☒ **Other** Specify: Entity under contract with MDHHS to review LOC records	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

1) MDHHS contacts with an EQRO that employs qualified reviewers to conduct case record reviews on a sample of cases to compare level of care determinations (LOCDs) with actual assessments. Qualified reviewers analyze findings and verify that enrolled participants are eligible, LOCD items match comparable assessment responses, and supports coordinators reevaluate enrollees at least annually. The EQRO compiles results into the final written review report provided to the waiver agency. When qualified reviewers identify non-compliance, immediate remediation is required and pursued. Additionally, qualified reviewers may provide instructions for assuring compliance and MDHHS staff provides training as needed.

2) MDHHS or its designee conducts verification reviews to validate the accuracy of the LOCDs completed by waiver agencies. The waiver agency must submit all supporting documentation requested by MDHHS or its designee.

3) MDHHS uses an edit process within the Medicaid Management Information System (CHAMPS) to prohibit generation of a capitation payment for participants who do not have a valid LOCD.

4) MDHHS reviews LOCD appeal and decision summaries regularly, provides technical assistance and training, and initiates corrective actions as needed.

5) MDHHS policy requires each waiver agency to use the established LOCD process and forms. Waiver agencies have first line responsibility for ensuring on a continual basis that supports coordinators determine participants eligible by using this process and MDHHS requires them to monitor determinations for errors and omissions. MDHHS requires the waiver agencies to have written procedures that follow MDHHS policy. As part of the verification review process, MDHHS or its designee ensures that the waiver agency uses the LOCD process and instruments described in the waiver application to determine level of care.

6) The new strategy for reviewing LOCDs will be in addition to the existing quality assurance and monitoring efforts. It provides additional program integrity. The statistically significant random sample for the new LOCD review process will be a different sample from that pulled for the clinical quality assurance review conducted by the EQRO for the existing quality assurance process, though some cases may overlap based on the nature of a random sample.

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

b. Methods for Remediation/Fixing Individual Problems

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

During reviews conducted to validate the LOCD, if an applicant is found to be ineligible for the nursing facility level of care, the waiver agency must help the participant find alternative services in the community. Then the participant must be disenrolled from the MI Choice program and given their appeals rights. MDHHS will recover all Medicaid capitation payments made during the period of ineligibility. LOCDs resulting from such reviews may be appealed by the waiver agency through procedures established by MDHHS.

If during the CQAR, any waiver participant is found to not have a level of care redetermination within 12 months of the participant's last evaluation, the waiver agency must conduct a level of care evaluation within two weeks of notification of finding, if one has not already been conducted.

During the LOCD review or the CQAR, if any LOCDs were incorrectly applied, the waiver agency must conduct a new LOCD within two weeks of notification of the finding. If the participant originally was found ineligible for the waiver program, but the LOCD finds the participant eligible, the participant must be enrolled with the program as soon as possible. If the LOCD was done incorrectly but eligibility does not change, the waiver agency must conduct a new NFLOC review of the participant with supervisory oversight.

If during the CQAR, any level of care determinations are found to be conducted by someone unqualified, the waiver agency must conduct a new LOCD by someone who is a qualified evaluator. If a new LOCD is performed by a qualified evaluator and an applicant is found to be ineligible for MI Choice, MDHHS must disenroll the participant from the program, offer them appeal rights, and recover all Medicaid capitation payments made during the period of ineligibility.

If any NFLOCs are found to have been conducted inappropriately after MDHHS review, a new NFLOC tool will need to be conducted and entered into the NFLOC system. If the participant no longer meets NFLOC, the waiver agency must start disenrollment procedures with the participant, including notification of the individual's right to appeal.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

The applicant, or legal representative, must be informed of the following services available to persons meeting the nursing facility level of care. Services available in a community setting include MI Choice, PACE, Home Health, Home Help, MI Health Link or nursing facility institutional care.

If applicants are interested in community-based care, but currently reside in a nursing facility, the nursing facility must provide appropriate referral information. Applicants who prefer a community long term care option, but are admitted to a nursing facility because of unavailable capacity or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must indicate their choice of program in writing by signing the Freedom of Choice (FOC) form. A completed copy of this form must be retained for a period of 10 years. The completed form must be kept in the case record if the participant chooses MI Choice. The FOC form must also be witnessed by an applicant's representative when available. MDHHS ensures that waiver agencies inform participants of long term care choice through the review of LOCDs, which is performed by a peer review organization contracted with MDHHS and the CQAR process. The peer review organization and qualified reviewers verify that waiver agencies have signed FOC forms in the participants records indicating that choice has been offered and discussed.

The waiver agency is responsible for providing the information about various program options to the individuals. There is a Freedom of Choice form the individual signs indicating information about various programs was provided and he/she chose MI Choice.

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

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

Appendix B: Participant Access and Eligibility

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

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

Waiver agencies are required to provide language and culturally sensitive information to all applicants for MI Choice. Depending on the local community, brochures are printed in Spanish, French, Arabic, Polish, and Chinese. In meeting with individual waiver applicants or participants, waiver agencies may employ bilingual staff, or use translation services. The MI Choice Participant Handbook is available on the MDHHS website in English, Arabic, Spanish, and Russian.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**Respite**		
Statutory Service	**Supports Coordination**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		
Supports for Participant Direction	**Fiscal Intermediary**		
Supports for Participant Direction	**Goods and Services**		
Supports for Participant Direction	**Supports Brokerage**		
Other Service	**Assistive Technology**		
Other Service	**Chore Services**		
Other Service	**Community Health Worker**		
Other Service	**Community Living Supports**		
Other Service	**Community Transportation**		
Other Service	**Counseling**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**Nursing Services**		
Other Service	**Personal Emergency Response System**		
Other Service	**Private Duty Nursing/Respiratory Care**		
Other Service	**Residential Services**		
Other Service	**Training**		
Other Service	**Vehicle Modifications**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Transportation between the participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health Centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does not offer transportation, or does not offer it to the participant's residence, then MI Choice would pay for the transportation to and from the Adult Day Health Center separately.

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

Participants cannot receive Community Living Supports while at the Adult Day Health facility. Payment for Adult Day Health Services includes all services provided while at the facility. Community Living Supports may be used in conjunction with Adult Day Health services, but cannot be provided at the exact same time.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

2. The provider must require staff to participate in orientation training as specified in MI Choice policy and contract. Additionally, program staff must have basic first-aid training.

The provider must require staff to attend in-service training at least twice each year. The provider must design this training specifically to increase their knowledge and understanding of the program and participants, and to improve their skills at tasks performed in the provision of service. The provider must maintain records that identify the dates of training, topics covered, and persons attending.

3. If the provider operates its own vehicles for transporting participants to and from the program site, the provider must meet the following transportation minimum standards:

a. The Secretary of State must appropriately license all drivers and vehicles and all vehicles must be appropriately insured.
b. All paid drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider must make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
c. All paid drivers must be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
d. Each program must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

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

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

6. Each day health center must have the following furnishings:

a. At least one straight back or sturdy folding chair for each participant and staff person.
b. Lounge chairs or day beds as needed for naps and rest periods.
c. Storage space for participants personal belongings.
d. Tables for both ambulatory and non-ambulatory participants.
e. A telephone located in a private area and accessible to all participants.
f. Special equipment as needed to assist persons with disabilities.

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

7. Each day health center must document that it is in compliance with:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those individuals normally providing services and supports for the participant. Services may be provided in the participant's home, in the home of another, or in a Medicaid-certified hospital, a licensed Adult Foster Care or Home for the Aged facility, a Medicaid-certified nursing facility, or another State approved facility. Respite does not include the cost of room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence.

Services include:

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

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

There is a 30-days-per-calendar-year-limit on respite services provided outside the home. The costs of room and board are not included except when respite is provided in a facility approved by the State that is not a private residence. Respite services cannot be scheduled on a daily basis, except for longer-term stays at an out-of-home respite facility. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals chosen by the participant who meet the qualification standards
Agency	Adult Foster Care
Agency	Home Care Agency
Agency	Homes for the Aged
Agency	Assisted Living - unlicensed
Agency	Long Term Care Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals chosen by the participant who meet the qualification standards

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. When Chore or Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category.

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

3. Providers must be at least 18 years of age, have the ability to communicate effectively both verbally and in writing, and be able to follow instructions.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Licensed by the State of Michigan as Adult Foster Care, Public Act 218 of 1979, licensing rules for Adult Foster Care Family Homes, Small Group Homes, Large Group Homes, Congregate Facilities

Certificate *(specify):*

Other Standard *(specify):*

Must meet federal Home and Community Based Services provider owned and controlled setting requirements as well as MDHHS provider monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies, MDHHS, and Licensing and Regulatory Affairs (for licensing requirements)

Frequency of Verification:

Prior to initial provider contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Respite services provided in licensed care settings must meet the standards set forth in applicable state and federal rules for home care agencies.

Certificate *(specify):*

Respite services provided in licensed care settings must meet the standards set forth in applicable state and federal rules for home care agencies.

Other Standard *(specify):*

When providing care in the home of the participant:

1. When Chore or Community Living Supports services are provided as a form of respite care, these services must also meet the requirements of the respective service category.

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

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

b. Verification of prescription medications and their dosages.

c. Instructions for entering medication information in participant files.

d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self administration of medications.

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

When providing respite in a licensed setting:

1. Each out-of-home respite service provider must be either a Medicaid certified hospital, long term care facility, or a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged.

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

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

Home care agencies are required to meet MDHHS requirements in the MI Choice provider monitoring tool.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Homes for the Aged

Provider Qualifications

License *(specify):*

Administrative Rules R325.1901-R325.1981.

Certificate *(specify):*

Other Standard *(specify):*

Must meet federal Home and Community Based Services provider owned and controlled setting requirements as well as MDHHS provider monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies, MDHHS, and Licensing and Regulatory Affairs (for licensing requirements)

Frequency of Verification:

Initial contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living - unlicensed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet federal Home and Community Based Services provider owned and controlled setting requirements as well as MDHHS provider monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies and MDHHS

Frequency of Verification:

Initial contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Long Term Care Facility

Provider Qualifications

License *(specify):*

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

Administrative Rules 325.20101-325-22004.

Certificate *(specify):*

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

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to service delivery and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Supports Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's person-centered service plan. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.

Functions performed by a supports coordinator include the following:

1. Conducting the initial and subsequent Nursing Facility Level of Care ASSESSMENT per state policy. (IN RESPONSE TO RAI)
2. Conducting the initial assessment and periodic reassessments.
3. Facilitating a person-centered planning process that is focused on the participant's preferences , includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports.
4. Developing a service plan using the person-centered planning process, including revisions to the service plan at the participant's initiation or as changes in the participant's circumstances may warrant.
5. Referral to and coordination with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or legal representation.
6. Monitoring of MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes opportunities for the participant to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.
7. Providing social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.
8. Providing advocacy in support of the participant's access to benefits, assuring the participant's rights as a program beneficiary, and supporting the participant's decisions.
9. Maintaining documentation of the above listed activities to ensure successful support of the participant, comply with Medicaid and other relevant policies, and meet the performance requirements delineated in the waiver agency's contract with the Michigan Department of Health and Human Services (MDHHS).

Communication is a required intervention and must be incorporated into the person-centered service plan.

Additional guidance for Supports Coordination can be found in the MI Choice policy chapter in the Medicaid Provider Manual.

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

Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supports Coordinator

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supports Coordination

Provider Category:

Agency

Provider Type:

Supports Coordinator

Provider Qualifications

License *(specify):*

Licensed in State of Michigan as:
Registered Nurse
Social Worker
Psychologist
Physical Therapist
Occupational Therapist

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements as specified in the MI Choice contract. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. In addition, the agency must maintain a pool of qualified supports coordinators from which the participant can choose. Qualified staff includes a Registered Nurse (RN), a Social Worker (SW), Physical Therapist, Occupational Therapist, or Psychologist with valid Michigan licenses to practice their profession as defined in the MI Choice contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDHHS verifies waiver agency qualifications. The waiver agency is responsible for assuring its employees and contracted providers meet provider qualifications for the service being delivered as specified in the MI Choice contract.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 4:	**Sub-Category 4:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

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

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

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies includes devices, controls, or appliances that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items.

This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's person-centered service plan.

All items must meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.

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

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

Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items that are not of direct medical or remedial benefit to the participant.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Stores
Agency	Enrolled Medicaid or Medicare DME Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Enrolled Medicaid or Medicare DME Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Each direct service provider must enroll in Medicare or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Fiscal Intermediary

HCBS Taxonomy:

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

12 Services Supporting Self-Direction	12010 financial management services in support of self-directio

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

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

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

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

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

Service Definition *(Scope):*

Fiscal Intermediary services assist participants in self-determination in acquiring and maintaining services defined in the participant's plan of service, controlling a participant's budget, and choosing staff authorized by the waiver agency. The fiscal intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's plan of service. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures, and assuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history reviews, and assisting the participant to understand billing and documentation requirements.

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

Fiscal Intermediary services are available only to participants choosing the self-determination option.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Intermediary Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Fiscal Intermediary Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Provider must be bonded and insured.

2. Insured for an amount that meets or exceeds the total budgetary amount the fiscal intermediary is responsible for administering. Demonstrated ability to manage budgets and perform all functions of the fiscal intermediary including all activities related to employment taxation, workers compensation and state, local and federal regulations. Fiscal Intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the participant, the family or guardians of the participant may provide fiscal intermediary services to the participant. Fiscal Intermediary service providers must pass a readiness review and meet all criteria sanctioned by the state. Fiscal intermediaries will comply with all requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to execution and annual renewal of contract.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Goods and Services are services, equipment or supplies not otherwise provided through either MI Choice or the Medicaid State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements. The item or service would:

Decrease the need for other Medicaid services,
Promote inclusion in the community, and
Increase the participant's safety in the home environment.

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

Goods and Services are only approved by CMS for self-direction participants. Experimental or prohibited treatments are excluded. (RESPONSE TO IRAI 8/9/2023) SPECIFIC GOODS AND SERVICES THAT ARE PURCHASED UNDER THIS COVERAGE must be documented in the person-centered service plan.

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

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

RESPONSE TO IRAI 8/9/2023: GOODS AND SERVICES PURCHASED UNDER THIS COVERAGE MAY NOT CIRCUMVENT OTHER RESTRICTIONS ON THE CLAIMING OF FFP FOR WAIVER SERVICES, INCLUDING THE PROHIBITION AGAINST CLAIMING FOR THE COSTS OF ROOM AND BOARD.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contract Provider
Agency	Retail Stores

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Goods and Services

Provider Category:

Individual

Provider Type:

Contract Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

RESPONSE TO IRAI 8/9/2023: PROVIDER OF THE SERVICE OR ITEM MUST BE ABLE TO LAWFULLY FURNISH THE SERVICE OR ITEM IDENTIFIED IN THE PCSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to contract execution AND ANNUALLY THEREAFTER (RESPONSE TO IRAI 8/9/2023).

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Goods and Services

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

RESPONSE TO IRAI 8/9/2023: PROVIDER OF THE SERVICE OR ITEM MUST BE ABLE TO LAWFULLY FURNISH THE SERVICE OR ITEM IDENTIFIED IN THE PCSP.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Supports Brokerage

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

The supports broker assists the participant or designated representative in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. The supports broker may provide information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the person-centered service plan.

Through this service, information may be provided to participant about:
- person centered planning and how it is applied;
- the range and scope of individual choices and options;
- the process for changing the plan of care and individual budget;
- the grievance process;
- risks and responsibilities of self-direction;
- free of choice of providers;
- individual rights;
- the reassessment and review schedules; and,
- such other subjects pertinent to the participant and/or family in managing and directing services.

Assistance may be provided to the participant with:
- defining goals, needs and preferences, identifying and accessing services, supports and resources;
- practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution, training in participant's care needs)
- development of risk management agreements;
- development of an emergency backup plan;
- recognizing and reporting critical events;
- independent advocacy, to assist in filing grievances and complaints when necessary; and,
- other areas related to managing services and supports.

This service may include the performance of activities that nominally overlap the provision of case management services. In general, such overlap does not constitute duplicate provision of services. For example, the supports broker may assist a participant during the development of a person-centered service plan to ensure that the participant’s needs and preferences are clearly understood even though a supports coordinator is responsible for the development of the service plan. Where the possibility of duplicate provision of services exists, the participant’s service plan should clearly delineate responsibilities for the performance of activities.

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

This service is limited to participants who direct some or all of their waiver services.
This service does not duplicate other waiver services, including supports coordination.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Supports Brokerage

Provider Category:

Individual

Provider Type:

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Unlicensed, but trained in the duties of the job.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14020 home and/or vehicle accessibility adaptations

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Assistive Technology is defined as: An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants or decrease social isolation. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

1. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
4. training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
5. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

RESPONSE TO IRAI 8/9/2023:
REOCCURRING INTERNET SERVICE COST DOES NOT FALL WITHIN THE PRIVY OF ASSISTIVE TECHNOLOGY.

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

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid or Medicare DME Provider
Agency	Retail Store
Individual	Individual Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Enrolled Medicaid or Medicare DME Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Retail Store

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Items purchased from retail stores must meet the Assisted Technology service definition. Waiver agencies must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Individual Contracted Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The item or service must be designed to meet the participant's functional, medical or social needs and advances the desired outcomes in the person-centered service plan.

The service or item is not prohibited by federal or state Medicaid or other statutes and regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to contract execution.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Chore Services are 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, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third
party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals chosen by the participant who meet the qualification standards
Agency	Home Care Agency, pest control providers, lawn care/snow plowing providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Individuals chosen by the participant who meet the qualification standards

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Home Care Agency, pest control providers, lawn care/snow plowing providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/a

Other Standard *(specify):*

1. Only properly licensed suppliers may provide pest control services.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Health Worker

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

The Community Health Worker (CHW) works with individuals who are re-enrolling in the MI Choice Waiver, or are enrolled in the MI Choice waiver after nursing facility or hospital discharge. The CHW visits the participant at home within three days of hospital or facility discharge to review the discharge paperwork and any other documentation, reviews any medications received or orders that need to be filled, reminds the participant of the importance of filling the medications, and talks with the participant about the importance of following up with the physician. If needed, the CHW may make calls for medication to be filled, or to arrange for the follow-up appointment with the physician. The CHW also trains the participant about anything to be aware of and what to do if his/her condition worsens. The CHW does another follow-up visit in 30 days to determine if the participant did follow up with the physician, take the prescribed medications, and follow any other discharge recommendations.

The CHW must thoroughly document what was discussed and discovered during the contacts with the participant so the Supports Coordinator is aware of what occurred. If there are medication discrepancies, the CHW will follow up with the RN Supports Coordinator to get those issues addressed.

The CHW may also visit the individual in the hospital or nursing facility to ensure the hospital or nursing facility knows who to contact to coordinate the discharge home. The CHW ensures the hospital or nursing facility staff has the contact of the Supports Coordinator with whom the discharge should be coordinated.

If the Supports Coordinator wishes, the CHW will be in contact with the nursing facility if a participant goes from a hospital to a nursing facility for temporary rehab before returning to the Waiver. The CHW may assist with coordinating any supplies, services, etc., the participant requires at home after rehab.

The CHW service is not limited to nursing facility or hospital transitions. The service is applicable to any participant who needs it.

The CHW may also perform the duties of a supports broker. They may provide assistance throughout the planning and implementation of the service plan to assist the participant in making informed decisions about what works best for the participant, assist the participant to explore the availability of community services and supports, assist with access to housing and employment, and assist with making the necessary arrangements to link the participant with those identified supports. CHW services offer practical skills training to enable individuals to remain independent, effective communication skills, and problem solving.

The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist the participants with completion of applications for programs for which they may be eligible.

Community Health Workers must work in close collaboration with the participant’s Supports Coordinator as the Supports Coordinator has ultimate responsibility for the participant’s case.

Most of the functions of the Community Health Worker (CHW) are separate, but may seem similar. The waiver agency must ensure there is no duplication. Similarly, some functions may seem similar between the CHW and Supports Coordinator, but if the CHW is performing the duty, the supports coordinator would just be coordinating with the CHW to ensure things are done for the participant and would not duplicate the work of the CHW.

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

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

RESPONSES TO IRAI 8/9/2023: IF THE CHW SERVICE IS USED WHILE A FORMER MI CHOICE PARTICIPANT IS TEMPORARILY IN THE HOSPITAL OR NURSING FACILITY, THE SERVICE WILL NOT BE CONSIDERED COMPLETE UNTIL THE INDIVIDUAL RETURNS HOME AND RE-ENROLLS IN THE MI CHOICE PROGRAM. THEREFORE, THE DATE OF SERVICE WILL BE THE MI CHOICE RE-ENROLLMENT DATE. THIS SERVICE CANNOT BE PROVIDED THROUGH MI CHOICE IF THE INDIVIDUAL IS ALSO RECEIVING COMMUNITY TRANSITION SERVICES.

(IN RESPONSE TO RAI)
IF THE COMMUNITY HEALTH WORKER IS EMPLOYED BY THE WAIVER AGENCY, THIS INDIVIDUAL MAY NOT ALSO ACT AS A SUPPORTS BROKER DUE TO POTENTIAL CONFLICT OF INTEREST. THE SUPPORTS BROKER ROLE IS PERFORMED BY AN INDIVIDUAL EXTERNAL TO THE WAIVER AGENCY TO ENSURE SEPARATE LINES OF AUTHORITY.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organization or entity other than an individual provider
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Health Worker

Provider Category:

Agency

Provider Type:

Organization or entity other than an individual provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Trained in duties of the job.

Trained waiver agency staff may be utilized if there were no other willing and qualified providers for the CHW service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Health Worker

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Unlicensed, but trained in the duties of the job.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracted waiver agencies

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08050 homemaker
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it must not also be authorized as a separate waiver service for the beneficiary.
Community Living Supports includes:

1. Assisting, reminding, cueing, observing, guiding and/or training in household activities, activities of daily living or routine household care and maintenance.
2. Reminding, cueing, observing and/or monitoring of medication administration.
3. Assistance, support and/or guidance with such activities as:
a. non-medical care (not requiring nurse or physician intervention) - assistance with eating, bathing, dressing, personal hygiene, and activities of daily living;
b. meal preparation, but does not include the cost of the meals themselves;
c. money management;
d. shopping for food and other necessities of daily living;
e. social participation, relationship maintenance and building community connections to reduce personal isolation;
f. training and/or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work;
g. transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence;
h. routine household cleaning and maintenance;
4. Dementia care, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan;
5. Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
6. Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.

These service needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from any services in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for community living supports tasks as provided under the waiver than the requirements for these types of services under the State Plan.

Spouses and legally responsible adults are allowed to be paid caregivers in limited situations. They must not be hired via the self-determination arrangements. These individuals must be hired by a home care agency that will provide supervision and oversight to ensure services are being delivered.

Each direct service provider who chooses to allow staff to assist participants with self-medication must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum:
• The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant.
• Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.
• Instructions for entering medication information in participant files.
• A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:
• A provider must only administer medication at the order of a physician and in compliance with the provisions of

section 719 of the act, if applicable.
• A provider must ensure that medication use conforms to federal standards and the standards of the medical community.
• A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
• A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status.
• If an participant cannot administer his or her own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
• A provider must record the administration of all medication in participant's clinical record.
• A provider must ensure that staff report medication errors and adverse drug reactions to the participant's physician immediately and properly, and record the incident in the participant's clinical record.

RESPONSE TO IRAI 8/9/2023: EXAMPLES REMOVED, BELOW LANGUAGE ADDED IN CAPITAL LETTERS.
CLS services may ALSO be provided to participants while in the ACUTE CARE hospital in limited circumstances. MI Choice cannot duplicate services the hospital provides. WHEN COMMUNITY LIVING SUPPORTS ARE PROVIDED IN THE ACUTE CARE HOSPITAL, IT CANNOT INCLUDE HOMEMAKING TASKS.
• THE HCBS ARE PROVIDED TO MEET NEEDS OF THE INDIVIDUAL THAT ARE NOT MET THROUGH THE PROVISION OF ACUTE CARE HOSPITAL SERVICES;
• THE HCBS ARE IN ADDITION TO, AND MAY NOT SUBSTITUTE FOR, THE SERVICES THE ACUTE CARE HOSPITAL IS OBLIGATED TO PROVIDE;
• THE HCBS MUST BE IDENTIFIED IN THE INDIVIDUAL'S PERSON-CENTERED SERVICE PLAN; AND
• THE HCBS WILL BE USED TO ENSURE SMOOTH TRANSITIONS BETWEEN ACUTE CARE SETTING AND COMMUNITY-BASED SETTINGS AND TO PRESERVE THE INDIVIDUAL'S FUNCTIONAL ABILITIES.

CLS OFFERED IN THE ACUTE CARE HOSPITAL SETTING WILL ASSIST THE INDIVIDUAL WITH TRANSITION TO A COMMUNITY SETTING BECAUSE THE CLS WORKER WILL BE MORE KNOWLEDGEABLE ABOUT CARE NEEDS AFTER DISCHARGE, CAN BETTER ASSIST WITH ANY CHANGES TO THE SERVICE PLAN UPON DISCHARGE, AND COMMUNICATE WITH PROVIDER AGENCY AND WAIVER AGENCIES TO GET SERVICE IN PLACE AFTER DISCHARGE. THE INDIVIDUAL'S NEEDS WILL BE MET DURING THE HOSPITAL STAY, PREVENTING ADDITIONAL COMPLICATIONS OR NURSING FACILITY ADMISSION.

MDHHS DOES NOT EXPECT ANY CHANGE TO REIMBURSEMENT RATES FOR CLS PROVIDERS WHILE THE PARTICIPANT IS IN THE HOSPITAL.

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

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

Community Living Support services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere. The distinction must be apparent by unique hours and units in the approved service plan.

A participant's spouse may not be paid with MI Choice funds for homemaking tasks, but can perform tasks such as personal care, feeding or tasks not considered homemaking.

CLS cannot be provided in residential settings such as Adult Foster Care, Homes for the Aged, or other assisted living facilities. Residential services must be used instead.

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

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

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals chosen by the participant who meet the qualification standards
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Individual

Provider Type:

Individuals chosen by the participant who meet the qualification standards

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be trained in universal precautions and blood-born pathogens and be in good standing with the law as validated by a criminal history review conducted by the waiver agency. Training in cardiopulmonary resuscitation can be waived if providing services for a participant who has a "Do Not Resuscitate" (DNR) order. If providing transportation incidental to this service, the provider must possess a valid Michigan drivers license.

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

3. Previous relevant experience and training to meet MDHHS operating standards. Refer to the MI Choice contract for more details.

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

5. Trained in how to perform ventilator CPR, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Transportation (CT) services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the individual's plan of services.

The CT service may also be utilized for expenses related to transportation and other related travel expenses determined necessary to secure medical examinations/appointments, documentation, or treatment for participants. (ADDED IN RESPONSE TO RAI) PAYMENT FOR TRANSPORTATION UNDER THE WAIVER IS LIMITED TO THE COSTS OF TRANSPORTATION NEEDED TO ACCESS A WAIVER SERVICE INCLUDED IN THE PARTICIPANT'S PERSON-CENTERED SERVICE PLAN OR ACCESS OTHER ACTIVITIES AND RESOURCES IDENTIFIED IN THE PERSON-CENTERED SERVICE PLAN.

Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT services through the MI Choice program.

Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies who can provide transportation services without charge must be utilized before MI Choice provides transportation services. (LANGUAGE MOVED IN RESPONSE TO RAI)

IN RESPONSE TO RAI:
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 DOES NOT REPLACE THEM.

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

Waiver agencies must not use this service to authorize MI Choice funds to reimburse caregivers (paid or informal) to run errands for participants when the participant does not accompany the driver of the vehicle. The purpose of Community Transportation is for the participant to gain access to the community.

When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health or Community Living Supports), there must be mechanisms to prevent duplicative billing for transportation.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Contracted provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Valid Michigan Driver's License

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The vehicle owner must have automobile insurance required by Michigan Law.

2. All drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. Drivers must also be physically capable and willing to provide assistance to get from the pick-up location to the vehicle and from the vehicle to the drop-off location.

3. Each driver and passenger must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Contracted provider

Provider Qualifications

License *(specify):*

Valid Michigan Driver's License

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The provider must have vehicle insurance required by Michigan Law.

2. All drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. Drivers must also be physically capable and willing to provide assistance to get from the pick-up location to the vehicle and from the vehicle to the drop-off location. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

3. The provider shall train all drivers to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

4. Each driver and passenger must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation.

Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral health needs.

Counseling may be provided via telehealth (virtually with a video component). For this telehealth option, the participant must consent to this method. Privacy of the participant must be maintained at all times. (IN RESPONSE TO RAI) THE PREFERRED METHOD OF DELIVERY IS IN-PERSON, BUT THE TELEHEALTH OPTION MAY BE USED TO INCREASE ACCESS TO THE SERVICE OR UPON PARTICIPANT PREFERENCE, AS SPECIFIED IN THE PERSON-CENTERED SERVICE PLAN. INDIVIDUALS WHO RECEIVE COUNSELING THROUGH TELEHEALTH WILL BE BETTER ABLE TO INTEGRATE WITHIN THEIR COMMUNITY BY RECEIVING ASSISTANCE TO RESOLVE THEIR PERSONAL ISSUES. MDHHS ESTIMATES THAT 20% OF PARTICIPANTS WILL USE THE TELEHEALTH OPTION STATEWIDE. THE WAIVER AGENCY MUST VERIFY THAT THE TELEHEALTH OPTION FOR COUNSELING MEETS HIPAA REQUIREMENTS AND METHODOLOGY. SOME PARTICIPANTS MAY CHOOSE TO HAVE THE COUNSELING SESSION WITHIN THEIR BEDROOM TO ASSURE PRIVACY FROM OTHER MEMBERS OF THE HOUSEHOLD. PRIVACY OF THE PARTICIPANT WILL BE MAINTAINED AT ALL TIMES. WHEN AN INDIVIDUAL REQUIRES ASSISTANCE TO ACCESS COUNSELING SERVICES VIA TELEHEALTH, THE WAIVER AGENCY WILL ASSURE THEY HAVE THE ASSISTANCE THEY NEED THROUGH EITHER INFORMAL SUPPORTS OR PAID SERVICES. RECEIPT OF THE COUNSELING SERVICE VIA THE TELEHEALTH OPTION WILL ENSURE HEALTH AND SAFETY BY ALLOWING INDIVIDUALS TO MAINTAIN COUNSELING APPOINTMENTS WHILE ISOLATING DUE TO INFECTIOUS ILLNESSES OR IMPROVING ACCESS TO COUNSELING SERVICES IN AREAS WITH LIMITED AVAILABLE PROVIDERS.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychologist
Individual	Social Worker
Individual	Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

MCL 333.18201 ... 333.18237

Certificate *(specify):*

N/A

Other Standard *(specify):*

a. A master's or doctoral degree in psychology or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's or doctoral degree.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

MCL 333.18501 ... 333.18518

Certificate *(specify):*

N/A

Other Standard *(specify):*

a. A master's or doctoral degree in social work or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's or doctoral degree.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling

Provider Category:

Individual

Provider Type:

Counselor

Provider Qualifications

License *(specify):*

MCL 333.18101 ... 333.18117

Certificate *(specify):*

N/A

Other Standard *(specify):*

a. A master's or doctoral degree in counseling or

b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's or doctoral degree.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

MI Choice Environmental Accessibility Adaptations Service Definition:

Environmental Accessibility Adaptations (EAA) includes physical adaptations to the (RESPONSE TO IRAI 8/9/2023) PARTICIPANT'S PRIVATE RESIDENCE required by the participant's plan of service that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home.

Adaptations may include:

- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Modification of kitchen facilities;
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and
- Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers.

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

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

Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a participant's home.

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

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

The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

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

Adaptations may be made to rental properties when the lease or rental agreement does not indicate the landowner is responsible for such adaptations, and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the PAHP must specify any requirements for restoration of the property to its original condition if the occupant moves.

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

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

Excluded are those adaptations or improvements to the home that:

- Are of general utility;
- Are considered to be standard housing obligations of the participant or homeowner; and
- Are not of direct medical or remedial benefit.

Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

The MI Choice waiver does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. MI Choice waiver funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under constructions that require special adaptation to the plan (e.g. roll-in shower), the MI Choice waiver may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.

The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes. Environmental adaptations must exclude costs for improvements exclusively required to meet local building codes.

RESPONSE TO IRAI 8/9/2023: ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS MAY NOT BE FURNISHED TO ADAPT LIVING ARRANGEMENTS THAT ARE OWNED OR LEASED BY PROVIDERS OF WAIVER SERVICES.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Stores
Individual	Contracted Provider
Agency	Contracted provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Retail Stores

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Items purchased from retail stores must meet the Environmental Accessibility Adaptation service definition. Waiver agencies must be prudent with their purchases and may have a business account with the retail store.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Contracted Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

N/A

Other Standard *(specify):*

Each waiver agency must develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to service execution.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contracted provider

Provider Qualifications

License *(specify):*

MCL 339.601(1), MCL 339.601.2401, MCL 339.601.2404(3)

Certificate *(specify):*

N/A

Other Standard *(specify):*

Each waiver agency must develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to contract execution.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the participant's service plan. A Home Delivered Meal cannot constitute a full nutritional regimen.

HDM includes meal delivery kits. HDM also includes service or membership fees for grocery delivery services.

To be eligible for meal delivery kits, the following must be met:
1. The meals are for the participant
2. The participant must be able to prepare the meal or have someone available to prepare the meal
3. The participant must have the capacity to properly store the meal components

Grocery delivery service:
1. Must not include payment for the food
2. Must have difficulty with one or more of the following or quarantine due to illness or public health emergency:
a. getting to the grocery store
b. selecting groceries in the store
c. transporting groceries from store to home

RESPONSE TO IRAI 8/9/2023:
THIS SERVICE MUST INCLUDE AND PRIORITIZE HEALTHY MEAL CHOICES THAT MEET ANY ESTABLISHED CRITERIA UNDER STATE OR FEDERAL LAW. MEAL OPTIONS MUST MEET ENROLLEE PREFERENCES IN RELATION TO SPECIFIC FOOD ITEMS, PORTION SIZE, DIETARY NEEDS, ALLERGY RESTRICTIONS, AND CULTURAL AND/OR RELIGIOUS PREFERENCES. EACH PROVIDER SHALL DOCUMENT MEALS DELIVERED. THE PCSP MUST REFLECT THE NEED AND WHETHER THE HOME DELIVERY KIT MEETS THE NEEDS OF THE ENROLLEE (E.G., ENROLLEE HAS A NEED TO ACCESS TO GROCERIES OR A PREFERENCE FOR MEAL DELIVERY KITS AND INDIVIDUAL IS CAPABLE OF (OR HAS ASSISTANCE) COMPLETING THE LEVEL OF PREPARATION REQUIRED WITH THE MEAL DELIVERY KIT MEALS). ENROLLEES HAVE A CHOICE OF ALL WILLING AND QUALIFIED PROVIDERS. THE OPTION FOR PREPARED MEALS THROUGH A TRADITIONAL HOME DELIVERED MEALS PROVIDER REMAINS AVAILABLE.

REIMBURSEMENT RATES FROM MDHHS TO WAIVER AGENCIES WOULD BE INCLUSIVE OF ANY HISTORICAL EXPERIENCE OF HOW THIS SERVICE WAS USED.

MEAL KIT PROVIDERS OFFER A SERVICE THAT SENDS PRE-PORTIONED INGREDIENTS, RECIPES, AND DIRECTIONS TO CUSTOMERS, USUALLY AS A SUBSCRIPTION SERVICE. THIS ALLOWS THE INDIVIDUAL TO COOK FRESH, HOMEMADE MEALS AT HOME. MEAL KIT PROVIDERS MUST OFFER A VARIETY OF MEALS FROM WHICH THE PARTICIPANT MAY CHOOSE AND THAT MEET THE NUTRITIONAL NEEDS OF THE PARTICIPANT.

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

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

The meals authorized under this service must not constitute a full nutritional regimen.

Limitations on who can get a meal:

a. The participant must be unable to obtain food or prepare complete meals.
b. The provider can appropriately meet the participant's special dietary needs and the meals available would not jeopardize the health of the individual.
c. The participant must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

RESPONSE TO IRAI 8/9/2023: THE PARTICIPANT MUST BE ABLE TO PREPARE THE MEALS AT HOME, OR HAVE A CARE GIVER THAT CAN PREPARE THE MEALS ON THE PARTICIPANT'S BEHALF.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Grocery Delivery Services
Agency	Meal Delivery Kit Providers
Agency	Home Delivered Meal Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Grocery Delivery Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Grocery stores or organizations that have staff or contractors to do grocery shopping for participants and deliver it to participant homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Meal Delivery Kit Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Companies such as Blue Apron, Hello Fresh, or similar that deliver meal kits that can be prepared at participant homes.

RESPONSE TO IRAI 8/9/2023:
MEAL KIT PROVIDERS OFFER A SERVICE THAT SENDS PRE-PORTIONED INGREDIENTS, RECIPES, AND DIRECTIONS TO CUSTOMERS, USUALLY AS A SUBSCRIPTION SERVICE. THIS ALLOWS THE INDIVIDUAL TO COOK FRESH, HOMEMADE MEALS AT HOME. MEAL KIT PROVIDERS MUST OFFER A VARIETY OF MEALS FROM WHICH THE PARTICIPANT MAY CHOOSE AND THAT MEET THE NUTRITIONAL NEEDS OF THE PARTICIPANT.
THE PARTICIPANT MUST BE ABLE TO PREPARE THE MEALS AT HOME, OR HAVE A CARE GIVER THAT CAN PREPARE THE MEALS ON THE PARTICIPANT'S BEHALF.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meal Provider

Provider Qualifications

License *(specify):*

Health Code Standards (PA 368 of 1978)

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Each home delivered meals provider must have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

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

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

4. The provider must deliver food at safe temperatures as defined in Home Delivered Meals service standards. Meals that are delivered in a frozen state must include directions on how to reheat the meals to a safe temperature.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to the delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Nursing Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

MI Choice Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse (RN). MI Choice Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services must not duplicate services available through the Medicaid State Plan or third payer resources.

When the participant's condition is unstable, could easily deteriorate, or when significant changes occur, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the participant. The supports coordinator must communicate with both the nurse providing this service and the participant's health care professional to assure the nursing needs of the participant are being addressed.

(IN RESPONSE TO RAI) ACTIVITIES AVAILABLE TO PARTICIPANTS AS SPECIFIED ON THEIR PERSON-CENTERED SERVICE PLAN:

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

Other Services

In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered (as defined under Michigan Complied Law (MCL) 333.7103(1))
- Setting up medications according to physician orders
- Monitoring participant adherence to their medication regimen
- Applying dressings that require prescribed medications and aseptic techniques
- Providing refresher training to the participant or informal caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing activities of daily living, or safe ambulation within the home

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

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

This service is limited to no more than two hours per visit. Participants receiving Private Duty Nursing services are not eligible to receive MI Choice Nursing Services.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Nurse (RN or LPN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201-17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

2. Each direct service provider must have written policies and procedures compatible with the MI Choice policy chapter in the Medicaid Provider Manual.

3. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services

Provider Category:

Individual

Provider Type:

Nurse (RN or LPN)

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201-17242, Registered Nurse or Licensed Practical Nurse (supervised by Registered Nurse)

Certificate *(specify):*

Other Standard *(specify):*

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

2. Each direct service provider must have written policies and procedures compatible with the MI Choice policy chapter in the Medicaid Provider Manual.

3. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided. PERS does not cover monthly telephone charges associated with phone service.

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

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PERS Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing/Respiratory Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11110 respitory therapy
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Private Duty Nursing (PDN) services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's person-centered service plan.

This service also includes Respiratory Care (RC) for participants who are ventilator dependent. The RC service includes provision of respiratory and ventilator assessment, treatment and observation by a licensed Respiratory Therapist.

To be eligible for PDN or RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's plan of service must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance.

PDN and RC for a participant between the ages of 18-21 is covered under the Medicaid State Plan.

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

• Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or

• Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or

• Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

• Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or

• Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions:
• "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.

• "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

• "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

• "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient

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

• "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in 3 or more activities of daily living.

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

Medical Criteria 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 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:

o Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;

o Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

o Deep oral (past the tonsils) or tracheostomy suctioning;

o Injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);

o Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;

o Total parenteral nutrition delivered via a central line and care of the central line;

o Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;

o Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

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

• Participants receiving MI Choice Nursing Services are not eligible to receive Private Duty Nursing/Respiratory Care (PDN/RC) services.

• Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

• The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

• PDN/RC is limited to persons aged 21 or older. PDN/RC is a Medicaid State Plan benefit for persons under the age of 21 who qualify for the service.

• All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria set forth in this application.

• The participant's physician, physician's assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to assure services are delivered according to that order.

• It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24 hours per day, 7 days per week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDHHS.

• 24/7 PDN/RC services cannot be authorized for persons who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These persons must have informal caregivers actively involved in providing some level of direct services to the participant on a routine basis.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency, Nurse
Individual	Nurse
Agency	Home Care Agency, Respiratory Therapist
Individual	Respiratory Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:

Agency

Provider Type:

Home Care Agency, Nurse

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 - 333.17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license. If the nurse is an LPN, they need to demonstrate how an RN provides supervision.

2. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:

Individual

Provider Type:

Nurse

Provider Qualifications

License *(specify):*

Nursing MCL 333.17201 - 333.17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license. If the nurse is an LPN, they need to demonstrate how an RN provides supervision.

2. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:

Agency

Provider Type:

Home Care Agency, Respiratory Therapist

Provider Qualifications

License *(specify):*

State of Michigan Respiratory Therapist license under MCL 333.18701-333.18713

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All Respiratory Therapist providing Respiratory Care to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.18701-333.18713, and maintain a current State of Michigan Respiratory Therapist license.

2. Services paid for with MI Choice funds shall not duplicate nor replace services available through the Michigan Medicaid State Plan. Waiver agencies and direct service providers can find State Plan coverage online in the Medicaid Provider Manual at www.michigan.gov/mdch.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing/Respiratory Care

Provider Category:

Individual

Provider Type:

Respiratory Therapist

Provider Qualifications

License *(specify):*

State of Michigan Respiratory Therapist license under MCL 333.18701-333.18713

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. All Respiratory Therapist providing Respiratory Care to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.18701-333.18713, and maintain a current State of Michigan Respiratory Therapist license.

2. Services paid for with MI Choice funds shall not duplicate nor replace services available through the Michigan Medicaid State Plan. Waiver agencies and direct service providers can find State Plan coverage online in the Medicaid Provider Manual at www.michigan.gov/mdch.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of services and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Residential Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02023 shared living, other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Residential Services are defined as: Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a setting that meets the home and community-based setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the assisted living provider.

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

Excludes payment specific to room and board, items of comfort or convenience, or costs of facility maintenance, upkeep, and improvement.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care.

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

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

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living - unlicensed
Agency	Homes for the Aged
Agency	Adult Foster Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services

Provider Category:

Agency

Provider Type:

Assisted Living - unlicensed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet federal Home and Community Based Services provider owned and controlled setting requirements as well as MDHHS provider monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies and MDHHS

Frequency of Verification:

Initial contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services

Provider Category:

Agency

Provider Type:

Homes for the Aged

Provider Qualifications

License *(specify):*

Administrative Rules R325.1901-R325.1981.

Certificate *(specify):*

Other Standard *(specify):*

Must meet federal Home and Community Based Services provider owned and controlled setting requirements as well as MDHHS provider monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies, MDHHS, and Licensing and Regulatory Affairs (for licensing requirements)

Frequency of Verification:

Initial contract and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Licensed by the State of Michigan as Adult Foster Care, Public Act 218 of 1979, licensing rules for Adult Foster Care Family Homes, Small Group Homes, Large Group Homes, Congregate Facilities.

Certificate *(specify):*

Other Standard *(specify):*

Must meet federal Home and Community Based Services provider owned and controlled setting requirements as well as MDHHS provider monitoring requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver agencies, MDHHS, and Licensing and Regulatory Affairs (for licensing requirements)

Frequency of Verification:

Prior to initial provider contract and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Training

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Training services consist of instruction provided to a MI Choice participant or unpaid caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's person-centered service plan. Training is covered for areas such as activities of daily living, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and
effective use of adaptive equipment.

(IN RESPONSE TO RAI) Training furnished to persons who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the person-centered service plan.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Social Worker
Individual	Registered Nurse
Agency	Home Care Agency
Individual	Physical Therapist
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

MCL 333.18501 ... 333.18518

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.18501 ... 333.18518 (social work).

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

MCL 333.17201 ... 333.17242

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 133.17201 ... 333.17242 (nursing).

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

MCL 333.17201 ... MCL 333.17242 (Nursing),MCL 133.17801 ... MCL 333.17831 (Physical Therapy), MCL 333.18301 ... MCL 333.18311 (Occupational Therapists), MCL 333.18501 ... MCL 333.18518 (Social Work)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

MCL 333.17801 ... 333.17831

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.17801 ... 333.17831 (Physical Therapist).

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

MCL 333.18301 ... 333.18311

Certificate *(specify):*

N/A

Other Standard *(specify):*

1. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:
MCL 333.18301 ... 333.18311 (Occupational Therapist).

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracting waiver agency.

Frequency of Verification:

Prior to delivery of service and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

The following are excluded:
- adaptations or improvements to the vehicle that are of general utility and not of direct medical or remedial benefit to the participant
- purchase or lease of the vehicle
- regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of MI Choice services. The costs of necessary adaptations to provider vehicles may be compensated in the payment rate for transportation or other services (e.g., Community Living Supports, Adult Day Health, Residential Services) that include the cost of transportation.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Modification Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Vehicle Modification Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must adhere to any state and federal requirements for vehicle accessibility adaptations and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracting waiver agency

Frequency of Verification:

Prior to delivery of the service and annually thereafter.

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

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

Each waiver agency and direct provider of home-based services must conduct a criminal history review through the Michigan State Police for each paid or volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct the reference and criminal history reviews before authorizing the employee to furnish services in a participants home.

A Fiscal Intermediary may conduct criminal background checks for participants in self-determination arrangements.

The scope of the investigation is statewide, conducted by the Michigan State Police.

Both waiver agency and MDHHS conduct administrative monitoring reviews of providers annually to verify that mandatory criminal history reviews have been conducted in compliance with operating standards.

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

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

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

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

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

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

Spouses and legally responsible adults are allowed to be paid PROVIDERS OF COMMUNITY LIVING SUPPORTS WHEN THE PARTICIPANT REQUIRES EXTRAORDINARY CARE (RESPONSE TO IRAI 8/9/2023). They must not be hired via the self-determination arrangements. These individuals must be hired by a home care agency that will provide supervision and oversight to ensure services are being delivered. These individuals may be caregivers for Community Living Supports in limited circumstances if hired through a home care agency TO ENSURE SUPERVISION/OVERSIGHT AND PAYMENT IS MADE FOR SERVICES RENDERED (RESPONSE TO IRAI 8/9/2023).

(RESPONSE TO IRAI 8/9/2023)
EXTRAORDINARY CARE: CARE EXCEEDING THE RANGE OF ACTIVITIES THAT A LEGALLY RESPONSIBLE INDIVIDUAL WOULD ORDINARILY PERFORM IN THE HOUSEHOLD ON BEHALF OF A PERSON WITHOUT A DISABILITY OR CHRONIC ILLNESS OF THE SAME AGE, AND WHICH ARE NECESSARY TO ASSURE THE HEALTH AND WELFARE OF THE PARTICIPANT AND AVOID INSTITUTIONALIZATION.

BEST INTERESTS OF PARTICIPANT: IT IS IN THE BEST INTEREST OF THE PARTICIPANT WHEN
- THE PARTICIPANT'S HEALTH OR MENTAL STATUS LIMITS THE PARTICIPANT'S ACCEPTANCE OF OTHER CAREGIVERS, OR
- NO OTHER QUALIFIED PROVIDERS ARE AVAILABLE TO FURNISH THE SERVICES, AND
- THE PARTICIPANT AGREES TO RECEIVE THE SERVICE FROM THE LEGALLY RESPONSIBLE INDIVIDUAL, AND
- LEGALLY RESPONSIBLE PROVIDER MEETS QUALIFICATIONS

☐ **Self-directed**

☒ **Agency-operated**

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

◉ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

○ **Other policy.**

Specify:

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

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

The waiver agency mails service provider application packages to potential service providers as requested. Provider applicants complete and submit agreement and assurance forms to the waiver agency. The waiver agency reviews all applicant requests to determine that providers are qualified to provide requested MI Choice service(s) prior to the provision of services and supports. There are no limits on the number of qualified service providers with which a waiver agency may contract, if all the standards, certifications and licensure requirements have been met.

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

MDHHS reviews new provider bid packets, contracting processes, provider monitoring, provider network lists, and policies and procedures related to providers to ensure that sufficient and qualified providers are available to serve participants.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of network providers that meet credentialing criteria initially and annually thereafter. Numerator: Number of contracted providers with proper credentials as verified by the waiver agency. Denominator: Number of contracted providers by waiver agency.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

Performance Measure:
Number and percent of waiver agency staff that receive training on diversity, equity and inclusion annually. Numerator: Number of waiver agency staff that receive training on diversity, equity and inclusion annually. Denominator: All waiver agency staff required to receive diversity, equity, and inclusion training.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of supports coordinators who receive training on critical incidents and person-centered planning annually. Numerator: Number of supports coordinators who receive training on critical incidents and person-centered planning annually. Denominator: Number of supports coordinators.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Waiver agencies enter into annual contracts with qualified providers. During the contract negotiation, waiver agencies review provider documents to assure the provider initially meets provider qualification and training requirements for the delivery of MI Choice services and confirm providers have active licenses and certification (all licensing information is available online). MDHHS approves the contracting process used by each waiver agency. MDHHS reviews and approves the bid packet used by each waiver agency. MDHHS reviews each agency's policies and procedures and contractor files (including bid packets, original applications and contracts) during the Administrative Quality Assurance Review (AQAR).

MDHHS reviews initial and annual provider monitoring reports submitted by waiver agencies to determine compliance with provider licensure and certification standards. MDHHS can request waiver agencies take action with their providers if they are concerned about their performance or interaction with participants. These actions can include required corrective action plans, additional provider monitoring or suspension or termination.

Waiver agencies send their provider network lists and updates to MDHHS. MDHHS reviews these to ensure enough providers are available to meet the needs of the population served. Provider lists and files are also reviewed during the AQAR.

Waiver agency staff reviews each provider file and documentation annually at the time of contract renewals. The providers must assure that they have the capacity to meet the performance standards of the services with qualified, trained and supervised employees. The providers' contractual responsibilities include conducting reference and criminal history reviews, reporting critical incidents, submitting accurate bills, maintaining accurate documentation and maintaining emergency response plans.

In addition, waiver agency staff conducts on-site monitoring reviews for a minimum of 20% of enrolled providers of recurrent services annually. Monitoring reviews use a template developed by MDHHS and includes compliance with MDHHS standards, delivery of services according to the participant's person-centered service plan, adequate staff supervision and training, and adequate participant case record documentation to support provider claims. Waiver agency staff evaluate providers of non-recurrent services to ensure compliance with MDHHS standards, delivery of services according to person-centered service plans, and adequate participant case record documentation to support provider claims. Waiver agencies also conduct home visits that confirm that providers furnish services according to the person-centered service plan and participant preferences and determine participant satisfaction with those services. Waiver agencies send all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process.

Additional Oversight

Description of administrative oversight exercised by MDHHS over the waiver agencies in order to assure that:

i. Providers meet provider qualifications and training requirements; and

MDHHS reviews and approves all contract templates prior to the waiver agency using them, which includes information about required qualifications and training. MDHHS reviews provider monitoring reports as they are submitted by the waiver agencies. MDHHS also reviews provider files, including the waiver agency bid packets, original applications and contracts and all provider related policies and procedures during the AQAR.

ii. Waiver agencies maintain a sufficient network of providers
MDHHS reviews annual provider network lists and any updates submitted by the waiver agencies to ensure enough providers are available to meet the needs of the population served. Provider lists and files are also reviewed during the AQAR.

b. Methods for Remediation/Fixing Individual Problems

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

Waiver agencies work with providers to meet MI Choice service standards and become qualified providers. If at any time the provider agency no longer meets requirements, the waiver agencies notify the provider of non-compliance and provide an opportunity for improvement and may need to recover all Medicaid payments made for the services rendered during the period of provider ineligibility. If after working with the waiver agency the provider still does not meet required standards, the waiver agency must first find alternate providers for any participants currently being served by the provider not meeting standards. Then the waiver agency will end their contract with the provider until they can provide proof of meeting standards. The waiver agency will need to recover all Medicaid payments made for the services rendered during the period of ineligibility. If the provider does not make the necessary improvements, the waiver agency terminates its contract with the provider and works with participants to find a new provider of service.

Providers also have requirements related to training. If it is discovered a provider is not meeting training requirements, the provider must make up those trainings within 30 days to continue providing services. Depending on the type of training needed, the provider may need to stop providing services until training can be secured. In this case, all participants affected must be assigned to different providers who can meet their needs.

Waiver agencies are required to conduct an in-depth monitoring of a sample of their providers annually. Within 30 days following completion of the review written findings and corrective action requirements are sent from the waiver agency to the provider. The waiver agency also sends all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process.

When results of the initial monitoring indicate any irregularities, the waiver agency must conduct further review of provider case records. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and is sent to the provider and MDHHS within 30 working days following completion of the review. Waiver agency staff must schedule a follow-up review within a three (3) to six (6) month timeframe for providers deficient in any part of the review to assure that the provider initiates corrective action.

If during the review of these written reports MDHHS has outstanding concerns, MDHHS can ask for additional documentation, reports, meetings, or may conduct site visits to assure issues are addressed. If necessary, depending on the provider’s deficiency, the waiver agency may suspend new referrals to the provider agency or transfer participants to another provider, adjust provider billings, or suspend or terminate the provider until the waiver agency can verify that the provider corrected deficiencies and changed procedural practices as required.

If a waiver agency has concerns or takes actions against a provider that may serve other waiver agencies, they contact the other waiver agencies to notify them of problems with the provider. MDHHS also reviews provider monitoring reports when submitted and during AQAR then notifies other waiver agencies if issues are identified. (See more detail on the AQAR in Appendix H)

MDHHS ensures that waiver agencies are appropriately remediating issues with qualified providers using the following procedures:

Written findings and corrective action requirements (as necessary) are sent from the waiver agency to the provider within 30 days following completion of the provider review. The waiver agency also must send all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. The written review includes citations of both positive findings and areas needing corrective action.

When results of the initial case record and bill review indicate any irregularities, the waiver agency must conduct further review of provider case records. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and is sent to the provider and MDHHS within 30 working days following completion of the review. Waiver agency staff must schedule a follow-up review within a three (3) to six (6) month timeframe for providers deficient in any part of the review to assure the provider initiates corrective action.

If during the review of these written reports MDHHS has outstanding concerns, MDHHS can ask for additional documentation, reports, meetings or may conduct site visits to assure issues are addressed.

MDHHS requires waiver agencies to submit the results of additional monitoring to MDHHS upon completion. MDHHS reviews this additional follow-up and contacts the agency if additional questions or concerns remain. MDHHS confirms waiver agency follow-up during AQARs and annual CQARs.

If a waiver agency has concerns or takes actions against a provider that may serve other waiver agencies, it contacts the other waiver agencies to notify them of problems with the provider. MDHHS also reviews provider monitoring reports when submitted and during AQAR, then notifies other waiver agencies if issues are identified with a provider also used by another waiver agency.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

C-3.

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

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

(IN REPONSE TO RAI)
1) MI Choice participants who reside in their own home or in the home of their relative (non-provider controlled) and receive home and community-based services comply with the federal HCB Settings requirements. These settings allow the participants to be in control of their life and be fully integrated in the community. Participants who choose to reside in a provider owned or controlled residential setting must reside in a setting that meets federal home and community-based setting requirements.

Residential settings include:
• Assisted Living Facilities (ALFs)
• Adult Foster Care (AFCs) homes
• Homes for the Aged (HFAs) and
• Independent Retirement Apartments

Non-Residential Settings include:
• Adult Day Health Care facilities

MDHHS assessed 100 percent of the MI Choice providers for HCB Settings compliance and requires all future providers to be assessed and compliant before they can be added to the provider network. MDHHS requires each provider-owned or provider-controlled setting to be compliant with the HCB Settings requirements before MI Choice services can be provided within that setting. To determine compliance, the waiver agency assesses the setting on-site using the CMS-approved "Residential Survey for MI Choice Waiver" assessment tool available on the MDHHS MI Choice webpage. The completed tools are submitted to MDHHS. MDHHS reviews the information, requests clarifications as needed, and makes the final determination on HCB settings compliance. MDHHS maintains a list of approved settings.

The HCB Settings Rule also applies to non-residential settings that provide Adult Day Health services. The process for determining compliance for non-residential settings aligns with the process used for residential settings. The CMS-approved "Non-Residential Survey for the MI Choice Waiver" is used for these settings.

The MI Choice process of assessing providers includes: all providers must have an on-site visit and survey by trained waiver agency staff. The waiver agencies must visit, administer, and complete the survey using the provider tools as part of the survey process. Waiver agencies interview provider staff and participants/residents to ensure the provider is compliant with all aspects of the Final Rule. Waiver agencies will gather and review all documents (leases, agreements, house rules, etc.) and make sure they comply with the HCB Settings Rule. The Waiver Agencies forward all surveys and documents to MDHHS for MDHHS review. MDHHS will determine if the setting is compliant with the HCB Settings Rule. If it is determined the setting is non-compliant, waiver agencies will work with the providers on becoming compliant. Once the provider is compliant, a new survey will be conducted and sent to MDHHS for review to determine compliance. As of March 17, 2019, all new providers must be in immediate compliance.

Any settings deemed non-compliant are not allowed to be included in the waiver agency's provider network. If a non-compliance is found after an initial compliant determination, the provider is given two weeks to come back into compliance. If this is not possible, MDHHS and the waiver agency work closely to inform participants of their options for seeking another compliant provider or terminating enrollment in MI Choice. In this scenario, all appropriate notices related to hearing and appeal rights are provided to participants as required.

Settings that require heightened scrutiny are evaluated on-site by MDHHS or a contracted entity that is not a waiver agency and the CMS-approved on-site monitoring tool is used to gather information. MDHHS and the heighted scrutiny review team then review the information and if approved submit it to CMS for final approval.

2) Methods of validation from MDHHS include 100 percent review of provider responses and survey, review of documentation and surveys, on-site reviews, and/or MDHHS site reviews. To ensure continued compliance, all providers will be reviewed for setting compliance each year at a minimum. Waiver agencies will verify that the providers continue to meet all criteria under the CMS HCBS Final Rule by conducting site visits and new survey's each year. MDHHS will ensure ongoing compliance by auditing a statistically significant sample of the settings surveyed each year using a combination of desk reviews and on-site reviews.

MDHHS incorporated HCBS settings requirements into quality reviews, provider monitoring, and consumer satisfaction surveys to identify areas of non-compliance. Each of these processes includes an examination of provider-controlled settings as appropriate to assure all settings adhere to the ruling.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

An independent supports broker with possession of a high school diploma, at least one year experience with older adults or persons with disabilities, works under the direction and oversight of a supports coordinator. In self-determined arrangements, an independent supports broker works under the control, employment and direction of the participant and may perform some of the functions otherwise delegated to the supports coordinator.

RESPONSES TO IRAI 8/9/2023: THE INDEPENDENT SUPPORTS BROKER COULD BE COVERED UNDER THE COMMUNITY HEALTH WORKER SERVICE AS LONG AS THAT INDIVIDUAL IS NOT AN EMPLOYEE OF THE WAIVER AGENCY.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Waiver agencies may directly employ supports coordinators. However, waiver agencies may also contract with other qualified INDIVIDUALS to provide supports coordination (REVISED IN RESPONSE TO RAI). Each waiver participant may use the qualified supports coordinator of their choice. Additionally, participants who choose the self-determination option can use an independent supports broker to assist in implementing, managing, and monitoring the plan and budget. When a participant uses an independent supports broker, the participant limits the supports coordinator's role in assisting the participant in planning, implementing, and managing service arrangements to avoid duplication of efforts. The supports coordinator retains the role of authorizing and monitoring the plan of service and individual budget.

Waiver agencies assign the responsibility for service plan development to supports coordinators. Supports coordinators do not provide other waiver services.

RESPONSES TO IRAI 8/9/2023:
1. TRAINED SUPPORTS COORDINATORS ARE THE ONLY WILLING AND QUALIFIED PROVIDERS AVAILABLE TO DEVELOP THE PERSON-CENTERED SERVICE PLAN.
2. IN MOST AREAS OF THE STATE, THERE IS A CHOICE OF WAIVER AGENCIES AND PARTICIPANTS ARE FREE TO TRANSFER BETWEEN THE TWO AGENCIES. ALL AGENCIES MUST OFFER CHOICE OF SUPPORTS COORDINATORS. SUPPORTS COORDINATORS DO NOT PROVIDE OTHER WAIVER SERVICES.
3. MDHHS EVALUATES SUPPORTS COORDINATOR PERFORMANCE THROUGH ANNUAL CLINICAL QUALITY ASSURANCE REVIEWS AND ANNUAL CAHPS PARTICIPANT SURVEYS CONDUCTED BY CONTRACTED ENTITIES.
4. SUPPORTS COORDINATORS DO NOT PROVIDE OTHER WAIVER SERVICES.
5. ALL WAIVER AGENCIES THAT OFFER OTHER WAIVER SERVICES HAVE ADMINISTRATIVE SEPARATION BETWEEN PERSON-CENTERED SERVICE PLAN DEVELOPMENT AND OTHER SERVICES. TWO WAIVER AGENCIES OFFER HOME DELIVERED MEALS AND ONE WAIVER AGENCY OFFERS COMMUNITY LIVING SUPPORTS. WAIVER AGENCIES ARE REQUIRED TO HAVE CHOICE OF PROVIDERS FOR ALL SERVICES.

IN RESPONSE TO RAI:

MDHHS REQUIRES WAIVER AGENCIES TO PROVIDE EACH APPLICANT AND PROGRAM PARTICIPANT A COPY OF THE MI CHOICE PARTICIPANT HANDBOOK. THIS HANDBOOK IS ALSO AVAILABLE ON THE MI CHOICE WEBSITE HERE: HTTPS://WWW.MICHIGAN.GOV/MDHHS/ASSISTANCE-PROGRAMS/MEDICAID/PORTALHOME/MEDICAID-PROVIDERS/PROGRAMS/MI-CHOICE-WAIVER-PROGRAM AND IN ENGLISH, ARABIC, RUSSIAN, AND SPANISH LANGUAGES. THIS HANDBOOK INCLUDES INFORMATION ABOUT ALL AVAILABLE SERVICES. PER 42 CFR §438.206 WAIVER AGENCIES (PAHPS) MUST MAINTAIN A NETWORK OF PROVIDERS SUFFICIENT TO PROVIDE ADEQUATE ACCESS TO ALL SERVICES COVERED UNDER THE CONTRACT FOR ALL ENROLLEES OR PROVIDE SERVICES THROUGH OUT-OF-NETWORK PROVIDERS. THE WAIVER AGENCIES ARE ALSO REQUIRED TO PROVIDE A LISTING OF THEIR NETWORK PROVIDERS TO APPLICANTS AND PARTICIPANTS.

MDHHS HAS A CLEAR AND ACCESSIBLE ALTERNATIVE DISPUTE RESOLUTION PROCESS IN PLACE SHOULD A PARTICIPANT DISPUTE THE STATE'S ASSERTION THAT THERE IS NOT ANOTHER ENTITY OR INDIVIDUAL THAT IS NOT THE INDIVIDUAL'S PROVIDER TO DEVELOP THE PERSON-CENTERED SERVICE PLAN. INDIVIDUALS MAY REPORT THEIR CONCERNS TO THE BENEFICIARY HELP LINE VIA EMAIL OR TELEPHONE CALL.

MDHHS IS AWARE OF AND APPROVES SITUATIONS WHERE WAIVER AGENCIES DIRECTLY PROVIDE MI CHOICE SERVICES. IN ALL CASES, THE WAIVER AGENCY IS REQUIRED TO OFFER A CHOICE OF PROVIDER FOR THE SERVICE, WHERE THERE IS AT LEAST ONE ADDITIONAL PROVIDER OF THE SERVICE THAT IS NOT THE WAIVER AGENCY. MDHHS ONLY APPROVES EXCEPTIONS TO THE CHOICE REQUIREMENT WHEN THERE ARE NO OTHER QUALIFIED, WILLING OR AVAILABLE PROVIDERS OF THE SERVICE WITHIN THE WAIVER AGENCY’S SERVICE AREA. BEFORE MDHHS WILL APPROVE AN EXCEPTION, THE WAIVER AGENCY MUST SUBMIT A PLAN

DESCRIBING STEPS THEY ARE TAKING TO EXPAND THEIR PROVIDER NETWORK OR DEVELOP ADDITIONAL PROVIDERS WITHIN THE SERVICE AREA.

MDHHS REVIEWS CASE RECORDS THROUGH THE QUALITY ASSURANCE PROCESS AND VERIFIES THE WAIVER AGENCY APPROVED APPROPRIATE SERVICES, OFFERED CHOICE OF PROVIDERS, AND AUTHORIZED SERVICES IN AN APPROPRIATE AMOUNT & DURATION. MDHHS ALSO ADMINISTERS THE CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS) SURVEY FOR HOME AND COMMUNITY-BASED SERVICES ANNUALLY AS ANOTHER WAY TO VERIFY THAT PARTICIPANTS ARE OFFERED CHOICE OF PROVIDERS AND CHOICE OF SERVICES.

WHEN WAIVER AGENCIES DIRECTLY PROVIDE MI CHOICE SERVICES, MDHHS REQUIRES ADMINISTRATIVE SEPARATION BETWEEN THE SUPPORTS COORDINATORS WHO ASSIST WITH DEVELOPING THE PERSON-CENTERED SERVICE PLAN AND STAFF THAT PROVIDE OTHER MI CHOICE SERVICES. THIS ADMINISTRATIVE SEPARATION IS REVIEWED AT LEAST ANNUALLY.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

a) Waiver agencies provide the MI Choice Participant Handbook and information packet to all applicants during the enrollment process. The information packet explains the MI Choice services, the person-centered planning process, rights and appeals information, information on elder abuse, and other information relevant to the service area. Waiver agencies solicit participant preferences for date, time, and place of the assessment meeting before finalizing schedules. The participant, the participant's chosen allies, and family or legal representatives are provided with written information about the right to participate in the person-centered planning process and the self-determination option upon enrollment in MI Choice, during assessment, reassessment, or upon request. The participant has the right to directly choose an independent supports broker to participate in development of the individual plan. The supports coordinator provides additional information and support and directly addresses issues and concerns the participant may have either over the phone or in a face-to-face meeting. Continued assistance from a supports coordinator is available throughout the person-centered service planning process. A participant who chooses the self-determination option may directly choose an independent supports broker. (RESPONSE TO IRAI 8/9/2023) As a result, the participant may choose to DELAY DEVELOPMENT OF THE PERSON-CENTERED SERVICE PLAN UNTIL SUCH TIME AS A SUPPORTS BROKER IS SECURED AND ABLE TO FULLY ASSIST WITH PERSON-CENTERED PLANNING AND THE SERVICE PLAN DEVELOPMENT PROCESS.

Participants agree to a preliminary person-centered service plan that will allow the waiver agency to provide services to the participant until a full person-centered planning meeting can be arranged with the chosen supports broker, supports coordinator, and participant. Upon completion of the full person-centered service plan, the preliminary service plan will be modified to the person-centered service plan developed during the meeting with the supports broker.

b) The participant has authority to determine who will be involved in the person-centered planning process and may choose allies, such as family members, friends, community advocates, service providers and independent advocates to participate. A participant who chooses the self-determination option may also include an independent supports broker, if the participant desires. Participants are informed of the availability of supports brokers during the enrollment process through the MI Choice Participant Handbook. Each waiver agency has a listing of qualified persons willing to perform this role for the participant. A participant may directly choose a supports broker to participate in development of the person-centered service plan. If preferred by the participant, a pre-planning conference may occur before the person-centered planning meeting. In this pre-planning conference, the participant and the supports coordinator discuss who the participant wants to involve in the planning process, goals and dreams that will be addressed, topics that will be discussed at the meeting and topics that will not be addressed. The time and location for the planning meeting is also determined at the pre-planning session.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Who develops the plan, who participates in the process, and the timing of the plan:
After completing the eligibility determination and initial assessment, the supports coordinators work with the participant and their representatives to develop the initial person-centered service plan. The team of supports coordinators includes an RN and a social worker. If the participant is experiencing a crisis situation that requires immediate services at the time of enrollment and is not ready to fully participate in person-centered planning, an interim service plan may be developed by the supports coordinator(s) and approved by the participant. Interim service plans are authorized for no more than 90 days without a follow-up meeting to determine the participant's status. The first person-centered planning meeting is conducted when the participant is not in crisis and at a time of the participant's choice.

A pre-planning session may occur before the first person-centered planning meeting. During pre-planning, the participant chooses dreams, goals and any topics to be discussed, who to invite, who will facilitate and record the meeting, as well as a time and location that meets the needs of all individuals involved in the process. The participant and selected allies design the agenda for the person-centered planning meeting. The person-centered service plan is based on the expressed needs and desires of the participant and is updated upon request of the participant. Regular updates to the service plan also occur when the need for services or participant circumstances change, but at least every 180 days.

(b) The types of assessments that are conducted to support the person-centered service plan development process, including securing information about participant needs, preferences and goals, and health status:
MI Choice uses the interRAI Home Care (iHC) assessment. Supports coordinators perform a comprehensive evaluation including assessment of the individual's unique preferences, physical, social and emotional functioning, medication, physical environment, natural supports, and financial status. The supports coordinator must fully engage the individual in the interview to the extent of the individual's abilities and tolerance. The participant must be reassessed 90 days after enrollment and annually thereafter.

The initial iHC assessment is required to be conducted in-person. Reassessments are to be completed in-person unless the participant prefers to have the iHC completed virtually with camera on. Telephonic assessments are not allowed. If an individual is in a nursing facility that is out of service area, or transferring to a new waiver agency in a different service area, MDHHS will allow the assessment to be conducted virtually with video on. In these out of service area situations, the assessment is not complete until the individual moves and an in-person assessment is completed in the new domicile within seven days.

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

The participant is informed of services available by the supports coordinator. This occurs through direct communication with the supports coordinator as well as through written information provided to the participant regarding waiver services and other available community services and supports. The participant is offered information on all possible service providers. The participant specifies how he/she wishes to receive services and this is included in the person-centered service plan. An independent supports broker may be used by participants who choose the self-determination option to access the identified needed services, locate providers and ensure implementation of services.

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

MDHHS has developed a person-centered planning practice guide for MI Choice waiver agencies. The document is available on the MDHHS MI Choice webpage to assist supports coordinators in ensuring that the person-centered service plan clearly identifies the participant's needs, goals and preferences with the services specified to meet them.

The supports coordinator and participant base the person-centered service plan upon participant preferences, goals, and needs identified through the person-centered planning process. A written person-centered service plan is developed with each participant and includes the individual's identified or expressed needs, goals, expected outcomes, and planned interventions, regardless of funding source. This document includes all services provided to or needed by the participant, is finalized within 90 days of enrollment, and approved by the participant. Supports coordinators arrange formal services based upon participant choice and approval. The participant and the supports coordinator explore other funding options and intervention opportunities when personal goals include things beyond the scope of MI Choice services.

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

The person-centered service plan clearly identifies the types of services needed from both paid and non-paid providers of services and supports. The amount (units), frequency, and duration of each waiver service to be provided are included in the person-centered service plan. The participant chooses the services that best meet their needs and whether to use the option to self-direct applicable services or rely on a supports coordinator to ensure the services are implemented and provided according to the person-centered service plan. When a participant chooses to participate in self-determination, information, support and training are provided by the supports coordinator and others identified in the person-centered service plan. When a participant chooses not to participate in self-determination, the supports coordinator ensures that services and supports are implemented according to the person-centered service plan. Supports coordinators oversee the coordination of State Plan and waiver services included in the person-centered service plans. This oversight ensures that waiver services in the person-centered service plans are not duplicative of similar State Plan services available to or received by the participant.

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

The assignment of responsibilities to implement the service plan are determined through person-centered planning and may be delegated to the participant, a supports coordinator, an independent supports broker, or others designated by the participant. The supports coordinator and the participant, to the extent the participant chooses, are responsible for monitoring the person-centered service plan. This occurs through periodic case reviews, regularly scheduled contacts, participant request, reassessments, and routine formal service provider monitoring of expenditures made on behalf of the participant. RESPONSE TO IRAI 8/9/2023: ONCE THE SERVICE PLAN IS FINALIZED, ALL INDIVIDUALS AND PROVIDERS RESPONSIBLE FOR IMPLEMENTATION FOR THE SERVICE PLAN SIGN AND RECEIVE A COPY OF THE PLAN.

(g)How and when the plan is updated:

Waiver agencies are required to contact participants at regularly scheduled intervals as preferred by the participant but not to exceed 90 days. Reassessments are conducted face to face 90 days after the initial assessment, with an annual reassessment thereafter, or upon a significant change in the participant's condition. Supports coordinators conduct a reassessment of the participant for the purpose of identifying changes that may have occurred since the initial assessment or previous reassessment and to measure progress toward meeting specific goals outlined in the participant's person-centered service plan. The participant may choose to have additional face to face meetings to specifically focus on the person-centered service plan at any time. The service plan is also reviewed and updated during this process, based upon reassessment findings and participant preferences. The person-centered service plan is also updated after changes in status and upon participant request. There must be a person-centered planning meeting every 180 days to review the person-centered service plan and update as necessary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Supports coordinators identify and discuss potential risks to the participant during the assessment and reassessments. The person-centered planning process specifies risks and methods of monitoring their potential impact in conjunction with the participant. The supports coordinators, or other qualified individuals, fully discuss strategies to mitigate risks with the participant and allies, family, and relevant others during person-centered planning. Participant approved risk strategies are documented and written into the person-centered service plan. Participants may be required to acknowledge situations in which their choices pose risks for their health and welfare. The waiver agency is not obligated to authorize services believed to be harmful to the participant. Negotiations of such issues are initiated in the person-centered planning process. Supports coordinators assess and inform participants of their identified potential risk(s) to assist participants in making informed choices with regard to these risks. Service providers are informed of a participant's risk status when services are ordered. Service providers, including waiver agencies, are required to have contingency plans in place in the event of emergencies that pose a serious threat to the participant's health and welfare (i.e., inclement weather, natural disasters, and unavailable caregiver).

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

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

In addition, the MI Choice Quality Improvement Strategy requires waiver agencies to monitor and track when back-up plans are activated and whether or not they are successful in an effort to make improvements in the way back-up plans are developed with participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The supports coordinator provides participants with information and training on selecting qualified service providers. Information may also be provided by the participant's trusted support network. Service providers must meet the minimum standards established by MDHHS for each service. Participants choose among qualified providers or employ providers who meet the minimum standards. Participants may receive assistance as needed to identify and select qualified providers at any time from supports coordinators or relevant others. A brochure on how to find and hire workers has been developed by MDHHS and is distributed to participants via the waiver agency.

RESPONSES TO IRAI 8/9/2023:
PARTICIPANTS MAY REFER BACK TO WRITTEN MATERIALS PROVIDED TO THEM DURING THE ASSESSMENT AND PCSP PROCESS IF THEY WISH TO CHANGE PROVIDERS. ADDITIONALLY, WAIVER AGENCIES ARE REQUIRED TO POST THE PROVIDER NETWORK ON A PUBLIC-FACING WEBSITE AS REQUIRED IN 42 CFR 438. MDHHS ALSO MAINTAINS A MI CHOICE WEBSITE WHERE THE DOCUMENTS ARE ALSO AVAILABLE. https://www.michigan.gov/mdhhs/assistance-programs/healthcare/seniors/michoicewaiver/mi-choice-waiver-program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Qualified supports coordinators are responsible for conducting, securing and verifying level of care (LOC) eligibility, conducting participant assessments and reassessments, initiating interim service planning and the person-centered planning process with participants, and specifying approval of person-centered service plans. MDHHS contracts with an EQRO which uses the CQAR process to meet CMS requirements for the review of person-centered service plan authorizations and case record reviews. The CQAR team uses a sample size program from www.raosoft.com/samplesize.html using a 95% confidence level and +/- 5% margin of error to determine total number of records to review for each waiver agency each fiscal year. Records reviewed are a completely random sample of MI Choice participants. In addition, for each waiver agency, the EQRO interviews approximately half of the participants in the record review sample. The selection of which participants are interviewed is also random. Qualified reviewers examine participant enrollment, assessment data, nursing facility level of care eligibility, the person-centered service plan and care planning process, and reassessment data to assure compliance with program standards and requirements.

Every self-determination budget is reviewed by at least two entities: waiver agencies and fiscal intermediaries. Fiscal intermediaries submit monthly reports for each participant directed budget. An additional sampling component is part of the service plan approval and authorization review for cases involving individual budgeting. This has been included to assure compliance with policies and guidelines associated with self-determination.

The EQRO conducts a random review of a representative sample of all MI Choice participants during the CQAR and if a self-determined individual falls into the random sample, the participant's file is reviewed as part of that sample. The reviewers are well-versed in the requirements of self-determination and assure all requirements are met within the case record. When requirements are not met, corrective action is required.

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

RESPONSES TO IRAI 8/9/2023: THE BASIS FOR THE SAMPLE SIZE IS THE TOTAL NUMBER OF PARTICIPANTS SERVED IN THE REVIEW PERIOD. THE REVIEWS ARE CONDUCTED ANNUALLY, AND REVIEW METHODOLOGY IS EXPLAINED IN THE QUALITY IMPROVEMENT SECTIONS IN THE WAIVER APPLICATION. THE CQAR TEAM USED THE RAOSOFT TOOL TO DETERMINE THE SAMPLE SIZE NEEDED FOR 95% CONFIDENCE LEVEL WITH OUR POPULATION SIZE AND ALLOWING FOR A 5% MARGIN OF ERROR. THE TOTAL SAMPLE SIZE WAS PROPORTIONED OVER THE 20 WAIVER AGENCIES, DEPENDING ON THEIR PERCENT OF THE TOTAL ENROLLMENT TO DETERMINE THE SAMPLE NEEDED FROM EACH WAIVER AGENCY. IF THE WAIVER AGENCY SAMPLE SIZE WAS LESS THAN 10, THE SAMPLE SIZE WAS ROUNDED UP TO 10.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that*

applies):

☐ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

The Waiver Agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) Entities responsible for implementation and monitoring are the waiver agency, supports coordinator, the independent supports broker, where applicable, the participant to the extent chosen by them, and the participant's support network, as appropriate. MDHHS contracts with and EQRO that employs qualified reviewers who conduct CQAR activities to ensure waiver agencies meet CMS and MDHHS requirements.
b) and c) Within two weeks of service implementation for newly enrolled participants, MDHHS requires waiver agencies to contact each participant to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies implement corrective actions to resolve problems and issues. MDHHS requires waiver agencies to contact each participant according to the frequency identified by the participant and documented in the person-centered service plan. If a back-up plan was required during the month, the supports coordinator will discuss the effectiveness of the plan and whether any changes are necessary. If the participant is not satisfied with a provider, the participant is given the choice to change workers or providers. Supports coordinators also confirm all non-waiver services are being furnished and the participant has access to any additional resources required. Participants and their families are provided with telephone numbers to contact waiver agencies and supports coordinators at any time when new needs emerge that require supports coordination interventions and additional support services. Self-determination participants and their support network also monitor the care and person-centered service plan including monitoring service budget utilization, time sheets of providers, and authorization for services to ensure services designated in the person-centered service plan have been accessed and provided in accordance with the plan. Participants and families are also educated on health and welfare and are encouraged to call their supports coordinator in the event of a potential critical incident. Reassessments are conducted 90 days after the initial assessment, with an annual reassessment thereafter, or upon a significant change in the participant's condition. The supports coordinator evaluates the effectiveness of back-up plans and the health and welfare of the participant at reassessment, upon participant request, and when there is a change in participant status or participant conditions.

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

If any critical incidents are suspected during the monitoring process or are reported by the participant, family, service provider, or any other individual, the waiver agency will act immediately to ensure the health and welfare of the participant. The waiver agency will present and discuss options to protect the participant to the participant and the participant's chosen allies. Any revisions to the person-centered service plan will be implemented immediately and followed-up on regularly.

Waiver agencies are responsible for on-going monitoring of person-centered service plan implementation and of direct service providers. Waiver agencies conduct a formal administrative review annually according to the MDHHS monitoring plan of direct service providers.
MDHHS examines waiver agency monitoring activities and reports during its AQAR process to ensure that monitoring activities are being conducted, service issues and problems are being resolved appropriately and timely, and any patterns of irregularities or concerns regarding a specific provider are identified.

RESPONSE TO IRAI 8/9/2023: THROUGHOUT THE SERVICE PLAN IMPLEMENTATION PROCESS, PARTICIPANTS EXERCISE THEIR FREE CHOICE OF PROVIDERS.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

The supports coordinator or the independent supports broker, along with the participant, are responsible for monitoring service plan implementation based on the participants choice. Although waiver agencies may provide direct waiver services, most are limited to Supports Coordination. Therefore, the waiver agency has no conflict in its role of monitoring service plan implementation and participant health and welfare. Participants are encouraged to monitor their own person-centered service plan implementation and alert or contact their supports coordinator or independent supports broker when they need assistance. The supports coordinator assists, supports, and provides training to the participant in evaluating provider performance of tasks based on the participants needs, preferences and goals as stipulated in the person-centered service plan. (IN RESPONSE TO RAI) THE INDEPENDENT SUPPORTS BROKER MAY ALSO PERFORM THESE TRAINING TASKS TO PARTICIPANTS WHO CHOOSE SELF-DETERMINATION. For participants choosing the self-determination option, use of a fiscal intermediary ensures that a participants individual budget is portable and that the function of selecting and managing providers of services and supports is separated from the function of person-centered service plan implementation. MDHHS also ensures that waiver agencies are monitoring service plan implementation and participant health and welfare by checking documentation during the AQAR and CQAR.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks. Numerator: Number of participants whose person-centered service plan had strategies to address their assessed health and safety risks. Denominator: Number of participant files reviewed.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants who indicate in the CAHPS HCBS survey that they are able to choose the services that matter to them. Numerator: participants who indicate in the CAHPS HCBS survey that they are able to choose the services that matter to them. Denominator: All responses to the Choosing Services that Matter to You category in the CAHPS HCBS survey.

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

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

		Random sample of individuals who meet the sample frame criteria: Enrolled for at least three months with at least one claim during that period. At least 30 completed surveys per waiver agency.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who report on the CAHPS HCBS survey that staff are reliable and helpful. Numerator: Number of participants who report on the CAHPS HCBS survey that staff are reliable and helpful. Denominator: Number of participant responses in this Staff are Reliable and Helpful CAHPS HCBS survey

category.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Contracted entity	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Random sample of individuals who meet the sample frame criteria: Enrolled for at least three months with at least one claim during that period. At least 30 completed surveys per waiver agency.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process. Numerator: Number of participants whose plan of service was developed appropriately. Denominator: Number of participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☒ **Other** Specify: EQRO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: bi-ennial	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants who received all of the services and supports identified in their person-centered service plan. Numerator: Number of participants who received all of the services and supports identified in their person-centered service plan. Denominator: Number of participant files reviewed.

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

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

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose records indicate choice was offered among waiver service providers. Numerator: Number of waiver participants whose records indicate choice was offered among waiver service providers. Denominator: All participant files reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%

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

Data Aggregation and Analysis:

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

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

1. Waiver agencies conduct monthly supervisory reviews of person-centered service plan development and updates to ensure each person-centered service plan addresses the participant's assessed needs, including risk management (RM) planning. Additionally, this review ensures supports coordinators include changes noted during participant assessments and reassessments into the person-centered service plan. Supervisory reviews result in written directives to individual supports coordinators requesting corrections and updates to the plan of service as needed.

2. Waiver agencies conduct peer reviews among supports coordinators within their own agency at least annually. This results in written peer feedback recommendations, sharing information resources, and improved care planning.

3. MDHHS requires a person-centered planning (PCP) process for the development of the person-centered service plan. Each waiver agency trains its staff and participants. The waiver agency maintains staff training records on attendance by date and total number of attendees, topics, and training evaluations. The EQRO validates that the waiver agency follows the PCP guidelines during the CQAR and MDHHS reviews training records during the AQAR. Participant training is documented in the case record and reviewed during the CQAR.

4. Supports coordinators assist participants in identifying risks during PCP and assure that the person-centered service plan includes RM planning. The person-centered service plan identifies participant risks with strategies and plans to reduce or eliminate risk as approved by participants. Supports coordinators monitor RM strategies and evaluate their effectiveness. MDHHS describes RM procedures in contract requirements.

5. MDHHS contracts with a third party vendor to conduct participant satisfaction and quality of life surveys. MDHHS uses the CAHPS HCBS survey. The vendor notifies the Waiver agencies as indicated to follow up with participants to correct any problems with service delivery. The vendor assures a statistically significant sample from each waiver agency and analyzes the data for any trends or possible system improvements that can be made locally or statewide. This analysis is provided to MDHHS and waiver agencies to use for quality improvement initiatives.

6. During the CQAR process, qualified reviewers perform annual person-centered service plan and case record reviews on a random sample of participants to ensure supports coordinators conduct person-centered service plan development according to MDHHS contract requirements, policy, and procedures. The CQAR process ensures the waiver agency authorizes and approves services in the person-centered service plan. Home visits confirm that providers furnish services according to the person-centered service plan and participant preferences. Additionally, the waiver agency confirms service delivery by monitoring direct service providers according to the required MDHHS waiver agency monitoring plan, which is in the MI Choice policy chapter in the Medicaid Provider Manual and the monitoring tool is located on the MI Choice webpage. Waiver agencies submit provider monitoring reports to MDHHS who reviews the reports and may request additional information based on the performance.

7. Supports coordinators validate that providers render services as planned during initial service implementation and a routine basis, frequency determined by participants. MDHHS requires waiver agency staff to follow-up with new participants within two weeks of arranging services or supports to ensure and document whether providers implemented the service as planned. MDHHS also requires waiver agency staff to contact participants at least monthly or as directed by the participant to ensure delivery of services as planned and participant satisfaction with services. Qualified reviewers examine these activities as part of the CQAR process. This includes verification that the waiver agency honored the participants choices of service setting (signed Freedom of Choice form) and the type of services rendered, and also ensured choice of service providers. Qualified reviewers analyze findings to ensure that participants receive services and supports consistent with identified needs and preferences. The EQRO then compiles the CQAR results and findings into written reports and sends them to the waiver agencies. The waiver agencies must identify a corrective action plan within 30 days of receiving the report. The EQRO reviews and approves the corrective action plan.

8. MDHHS requires the self-determination fiscal intermediary to send monthly monitoring reports to both the participant and the waiver agency. These reports identify the planned services and budget, the paid services, and a comparison of each. When budgets have more than a 10% discrepancy, MDHHS requires the waiver agency to

discuss this discrepancy with the participant to determine the root cause and identify methods of remediation as necessary. When a participant who chose the self-determination option is randomly selected for CQAR, the qualified reviewers assure the proper use of this, and other self-determination processes while reviewing the record.

Sampling Methodology:
The sampling methodology used randomly selects a statistically significant sample of MI Choice case records to review. The population includes participants who have been enrolled in MI Choice for at least 90 days in the review year. The process for making this selection is to use an online sample size calculator, using 95% confidence level and a standard deviation of .5. Once the total sample size is determined, that number is divided proportionately across waiver agencies based on population. The specific records reviewed for each agency are randomly selected using the systemic sampling method.

b. Methods for Remediation/Fixing Individual Problems

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

The EQRO or MDHHS staff may provide technical assistance to waiver agency staff when deficiencies are noted during the CQAR or AQAR.

During the CQAR process, qualified reviewers perform annual person-centered service plan and case record reviews on a random sample of participants to ensure supports coordinators conduct service plan development according to MDHHS contract requirements, policy, and procedures. During this review, if any participant person-centered service plan does not: include services or supports that align with their assessed needs; address health and safety risks; include goals and preferences; or are not developed in accordance with policies and procedures, the waiver agency must redesign the person-centered service plan within two weeks. This may require another person-centered planning meeting with the participant and others the participant wants included. The waiver agency must provide enough notice so that everyone can attend if they choose. Prior to implementing the new person-centered service plan, the participant must provide approval. MDHHS will monitor the revised person-centered service plan to ensure all requirements have been met.

Waiver agencies are required to review the person-centered service plan at least every 180 days with the participant and their chosen allies, or as needs change, and update as necessary. If any participant person-centered service plans are not updated as required and the situation has not already been remediated, MDHHS will require the waiver agency to conduct a face-to-face person-centered planning meeting to update the participant person-centered service plan as necessary within two weeks. The waiver agency must also follow-up with the participant regarding the person-centered service plan to ensure updates made are effective. The waiver agency must provide MDHHS with documentation that demonstrates the updates have been implemented.

Choice is important in the MI Choice program. During the CQAR, if a participant record does not contain a completed and signed freedom of choice form indicating preference to be in the MI Choice program, the waiver agency is required to obtain a complete and signed form specifying the participant was offered a choice between institution care and waiver services and chose the MI Choice program. The form must be sent to the EQRO to prove the remediation was made and added to the participant's record. If a waiver participant's record does not indicate choice was offered among waiver services or providers, the waiver agency will be required to provide information to the participant offering all waiver services and providers. Documentation must be provided to the EQRO and stored in the participant record to verify the participant was given a choice among services and providers.

Waiver agencies submit provider monitoring reports to MDHHS, who in turn reviews the reports and may request additional information based on performance. MDHHS may request waiver agencies take action with their providers if they are concerned about their performance or interaction with participants. MDHHS may ask waiver agencies to show how any issues were followed up on and remediated during AQAR. If necessary, MDHHS may request further corrective action plans to resolve outstanding issues.

A third party vendor conducts the CAHPS HCBS survey to measure participant's satisfaction and quality of life. The vendor notifies the Waiver agencies when indicated to follow up with participants to correct any problems noted on the completed surveys. The surveys are conducted on the phone or in person. The vendor assures a statistically significant sample from each waiver agency and analyzes the data for any trends or possible system improvements that can be made locally or statewide. This analysis and summarized data is provided to MDHHS and waiver agencies to use for quality improvement initiatives.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This option, referred to as self-determination, provides participants the option to direct and control their waiver services through an individual budget. Participants are supported in directing the use of the funds comprising their respective individual budgets for services designated in Appendix C. Supports coordinators work with participants to develop and revise individual budgets. Participants have the option of appointing a representative to assist them with directing their services and supports and obtaining additional assistance through participation in a peer support group and use of a supports broker.

Each waiver agency directly provides supports coordination and holds contracts with providers of services that conform to federal regulations. As participants exercise employer authority, each provider furnishing services is required to execute a Medicaid Provider Agreement with the waiver agency that conforms to the requirements of 42 CFR 431.107. Guidance for participant direction is provided through MDHHS contracts with each MI Choice waiver agency. The contract includes training, technical assistance, technical advisories, and prototype documents.

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

Waiver participants have opportunities for both employer authority and budget authority. Participants may elect one or both authorities, and can direct a single service or all of their services for which participant direction is an option. The participant may also allocate savings from services and supports in the person-centered service plan to purchase appropriate goods and services. The participant may direct the budget and directly contract with qualified chosen providers. The individual budget is transferred to a fiscal intermediary (an agency that provides financial management services), which administers the funds and makes payment to providers upon participant authorization.

Participants may choose to directly employ their worker or use the Agency with Choice option. With direct employment, the participant is the employer and delegates performance of the fiscal or employer agency functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant directly recruits, hires and manages employees. Detailed guidance is available to waiver agencies on the MI Choice website. In the Agency with Choice model, participants contract with an Agency and split the employer duties. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. The agency, as co-employer, is the common law employer, and handles the administrative and human resources functions and may provide other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. A participant may select one or both options.

RESPONSE TO IRAI 8/9/2023: THE MI CHOICE SELF-DETERMINATION GUIDELINES ARE LOCATED AT THE FOLLOWING WEBSITE AND DESCRIBE THE ROLE OF THE AGENCY WITH CHOICE (AWC): https://www.michigan.gov/mdhhs/assistance-programs/healthcare/seniors/michoicewaiver/mi-choice-waiver-program
AN AWC PROVIDER MUST DEVELOP A SYSTEM AND WRITTEN POLICIES AND PROCEDURES THAT INCORPORATE THE PHILOSOPHY AND PRACTICE OF SELF-DETERMINATION, FOR GUIDING PARTICIPANTS AND/OR THEIR CHOSEN LEGAL REPRESENTATIVES TO RECRUIT, INTERVIEW, AND SELECT WORKERS AND REFER THEM TO THE AWC FOR EMPLOYMENT. WITHIN THAT SYSTEM, BOTH THE PARTICIPANT AND THE AWC HAVE DEFINED ROLES AND FUNCTIONS. IN ITS ROLE AS THE EMPLOYER OF RECORD OF WORKERS, THE AWC PROVIDER HANDLES MANY OF THE EMPLOYER DUTIES.

A) FINANCIAL MANAGEMENT:
1. PROCESSING PAYROLL AND TIMESHEETS
2. WITHHOLDING, FILING, AND PAYING FEDERAL AND STATE INCOME TAX WITHHOLDING, FICA, FUTA, AND SUTA TO THE APPROPRIATE TAXING AUTHORITIES
3. PAYING WORKERS' COMPENSATION INSURANCE PREMIUMS
4. ISSUING FORMS W-2
5. MAINTAINING COMPLETE CURRENT FINANCIAL RECORDS, COPIES OF ALL AGREEMENTS, AND SUPPORTING DOCUMENTATION FOR EACH PARTICIPANT

B) HUMAN RESOURCES
1. FACILITATING THE COMPLETION OF CRIMINAL HISTORY SCREENINGS AND REFERENCE CHECKS
2. CONFIRMING THAT PROSPECTIVE WORKERS HAVE U.S. CITIZENSHIP OR LEGAL ALIEN STATUS
3. CONFIRMING THAT PROSPECTIVE WORKERS MEET PROVIDER REQUIREMENTS DEFINED IN THE MEDICAID PROVIDER MANUAL

4. PROVIDING TRAINING TO WORKERS, AS REQUIRED BY THE WAIVER AGENCY AND/OR THE AWC PROVIDER AND/OR DIRECTED BY THE PARTICIPANT
5. HANDLING FRINGE BENEFITS (SUCH AS HEALTH INSURANCE) FOR WORKERS

THE AWC PROVIDER CAN SET POLICIES FOR THE TYPES OF CRIMINAL HISTORY SCREENINGS THAT WOULD PRECLUDE EMPLOYMENT AND THE TYPES THAT WOULD NOT. IF THE WAIVER AGENCY HAS SPECIFIC POLICIES REGARDING CRIMINAL HISTORY, THIS CAN BE PART OF THE CONTRACT NEGOTIATING PROCESS. IT CAN ALSO SET FORTH REASONABLE PERSONNEL POLICIES THAT BOTH THE PARTICIPANTS AND THE WORKERS MUST FOLLOW. HOWEVER, THE AWC PROVIDER CANNOT PENALIZE THE PARTICIPANT OR THE WORKER FINANCIALLY IF THEY DECIDE THAT DIRECT EMPLOYMENT WOULD BE PREFERABLE AND DECIDE TO LEAVE THE AWC ARRANGEMENT.

THE AWC PROVIDER MAY ALSO PROVIDE SUPPORTIVE SERVICES AIMED AT ACHIEVING A SUCCESSFUL OUTCOME AS DETERMINED BY THE WAIVER AGENCY AND THE NEEDS OF THE PARTICIPANT. FOR EXAMPLE, THE PARTICIPANT CAN SEEK AND OBTAIN SUPPORT FROM THE AWC PROVIDER IN RECRUITING, SELECTING, AND HIRING WORKERS. IN SOME SITUATIONS, FAMILY, FRIENDS, OR THE SC MAY PROVIDE THAT SUPPORT.
(b) How participants may take advantage of these opportunities:

The MI Choice Participant Handbook is provided to each MI Choice participant and contains information on self-determination. Participants interested in the self-determination option start the process by informing their supports coordinator of their interest. The participants are given information regarding the responsibilities, liabilities and benefits of self-determination prior to the person-centered planning process. A person-centered service plan is developed through this process with the participant, supports coordinator, and allies chosen by the participant. The person-centered service plan includes MI Choice waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the person-centered service plan and must be sufficient to implement the person-centered service plan. The participant selects service providers and has the ability to act as the employer. Waiver agencies provide many options for participants to obtain assistance and support in implementing their person-centered service plans.

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

Supports coordinators (usually employed by waiver agencies) are the primary entities that support individuals who direct their own services. Supports coordinators are responsible for working with self-determination participants through the person-centered planning process to develop a person-centered service plan and an individual budget. Participants may choose to include a supports broker to assist them with planning services and supports and negotiating a budget. Supports coordinators are responsible for obtaining authorization of and monitoring the budget and plan. The supports coordinator and participant share responsibility for assuring participants receive the services to which they are entitled and for smooth implementation of the person-centered service plan. The MI Choice waiver provides many options for independent advocacy through involvement of a network of participant allies and independent supports brokers as described in Section E-1k.

Through its contract with MDHHS, each waiver agency is required to offer information and education on self-determination to participants. Each waiver agency also offers support to participants who choose this option. This support can include offering required training for workers, peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises.

Each waiver agency is required to contract with fiscal intermediaries to provide financial management services. The fiscal intermediary performs a number of essential tasks to support self-determination while assuring accountability for the public funds allotted to support this option.

The fiscal intermediary has four basic areas of performance:

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

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

participants, and contracting for other authorized goods and services;

3) Facilitate successful implementation of the self-determined services and supports by monitoring the use of the budget and providing monthly budget status reports to the participant and waiver agency; and

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

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

Participants may use an independent supports broker to assist with the development and implementation of the person-centered service plan and budget. Independent supports brokers, who are chosen by participants, work with and advocate for participants in conjunction with the supports coordinator.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Adult Foster Care, Homes For the Aged, unlicensed assisted living settings

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery**

methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction:

General information about self-determination options are provided to waiver participants by the waiver agency with a multi-layered approach that meets each participants' preferred method of communication. Every waiver participant receives the MI Choice Participant Handbook, which includes information about self-determination options. The supports coordinator explains the information in the Participant Handbook and answers questions the participant has. A brochure about self-determination has been developed for, and adapted by, the waiver agencies.

When a MI Choice participant expresses interest in participating in self-determination, the supports coordinator provides information and education to the participant, including the benefits responsibilities, and potential risks of choosing the self-determination option for the participant. Each participant develops a person-centered service plan that addresses specific options and concerns . The person-centered service plan addresses potential risks, concerns, and issues through the interventions included.

MDHHS provides support, training and technical guidance to the waiver agencies on developing local capacity and implementing options for self-determination. MDHHS developed technical advisories and guidelines on all aspects of self-determination to provide resources both to waiver agency staff and MI Choice participants. The documents are included in the guidance available on the MI Choice website and include:

- Guidance on how to administer self-determination in the MI Choice program
- Guidance on developing individual budgets
- When and how to rescind the self-determination option for participants
- Fiscal Intermediary functions
- Fiscal Intermediary Readiness Review
- Budget Forms
- Self-Determination Enrollment Form
- Medicaid Provider Agreement
- Self-Determination Disenrollment Form
- Back-up Workers
- Agency with Choice Agreement
- Agency with Choice Employment Agreement
- Employee Training Records
- Criminal History Screening Policy
- Right to Hire information
- Right to Hire Driver information
- An informational Self-Determination Flyer
- A Person-centered Planning brochure

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

The waiver agencies are responsible for disseminating this information to participants, and the supports coordinators primarily carry out this function. In addition, MDHHS staff provides information and training to provider agencies, advocates and participants on new materials and self-determination materials as needed.

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

This information is provided throughout the participant's enrollment in the MI Choice program. It starts from the time the participant initially enrolls in the program. Through the MI Choice Participant Handbook, participants are provided with information about the principles of self-determination and the possibilities, models and options available. The person-centered planning process is a critical time to address issues related to self-determination including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that participant concerns and needs are addressed. Self-determination options begin when the waiver agency and the participant reach agreement on a person-centered service plan, the funding authorized to accomplish the plan, and implementation of the plan. Each participant (or the participant's representative) who chooses to direct his or her services and supports signs a Self-Determination Agreement with the waiver agency that clearly defines the duties

and responsibilities of the parties.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Informal supports, such as non-legal representatives freely chosen by adult participants, can be an important resource for the participant. These individuals can include agents designated under a power of attorney or other identified persons participating in the person-centered planning process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the participant. Additionally, the supports coordinator contacts the participant on a regular basis and ensures the participant's representative is not authorizing self-determined services that do not fit the participant's preferences or do not promote achievement of the goals contained in the person's person-centered service plan. The supports coordinator assures the participant's person-centered service plan promotes independence and community inclusion and the representative does not act in a manner that conflicts with the participant's stated interests.

In the event the representative is working counter to the participants interests, the supports coordinator is authorized to address the issue and work with the participant to find an appropriate resolution.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Assistive Technology	☒	☒
Environmental Accessibility Adaptations	☒	☒
Goods and Services	☒	☒
Respite	☒	☒
Supports Brokerage	☒	☒
Chore Services	☒	☒
Fiscal Intermediary	☒	☒
Community Transportation	☒	☒
Nursing Services	☒	☒

Waiver Service	Employer Authority	Budget Authority
Community Living Supports	☒	☒
Private Duty Nursing/Respiratory Care	☒	☒
Community Health Worker	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Fiscal Intermediary Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Waiver agencies contract with private entities to furnish FMS as a waiver service. Each waiver agency must contract with at least one fiscal intermediary that meets the service standards defined in MI Choice policy and has passed the Fiscal Intermediary Readiness Review.

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

FMS entities contract with waiver agencies and are compensated via the waiver agency as a waiver service through the participant's individual budget.

(IN RESPONSE TO RAI)

THE TYPES OF ENTITIES THAT FURNISH FINANCIAL MANAGEMENT SERVICES ARE WELL DEFINED IN THE FISCAL INTERMEDIARY SERVICE DEFINITION. THEY ARE CONTRACTED VENDORS WITH THE WAIVER AGENCIES AND BEST ALIGN WITH AN ACCOUNTING FIRM. AS WITH ALL VENDORS IN THIS MANAGED CARE PROGRAM, THEY ARE CONTRACTED BY THE WAIVER AGENCIES (PAHPS) THROUGH AN OPEN BID PROCESS, WHICH ALIGNS WITH 45 CFR §75.329(D) OR 45 CFR §75.329(F). FURTHERMORE, 42 CFR §438.207(B)(2) REQUIRES THAT EACH WAIVER AGENCY (PAHP) "MAINTAINS A NETWORK OF PROVIDERS THAT IS SUFFICIENT IN NUMBER, MIX, AND GEOGRAPHIC DISTRIBUTION TO MEET THE NEEDS OF THE ANTICIPATED NUMBER OF ENROLLEES IN THE SERVICE AREA."

FISCAL INTERMEDIARIES CONTRACT WITH WAIVER AGENCIES. EACH WAIVER AGENCY MUST PROVIDE A CHOICE OF FISCAL INTERMEDIARY AND THEREFORE CONTRACT WITH MORE THAN ONE FISCAL INTERMEDIARY. MDHHS HAS A FISCAL INTERMEDIARY READINESS REVIEW THAT MUST BE COMPLETED BEFORE THE WAIVER AGENCY CAN CONTRACT WITH A FISCAL INTERMEDIARY. THIS IS AVAILABLE HERE: HTTPS://WWW.MICHIGAN.GOV/MDHHS/ASSISTANCE-PROGRAMS/MEDICAID/PORTALHOME/MEDICAID-PROVIDERS/PROGRAMS/MI-CHOICE-WAIVER-PROGRAM UNDER RESOURCES, THEN SELF-DETERMINATION GUIDELINES. OTHER THAN THE COMPLETION OF THE READINESS REVIEW, FISCAL INTERMEDIARIES ARE PROCURED IN THE SAME METHODS AS ALL OTHER PROVIDERS IN THE WAIVER AGENCY NETWORK.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

Conducts criminal history screenings on potential self-determined employees and verifies employees receive required provider training.

When the MMIS is able to enroll atypical Medicaid providers, all self-determined workers will enroll as an atypical provider in the MMIS and criminal history screenings will occur automatically through that system. Fiscal intermediaries will retain responsibility for informing participants when chosen providers are not qualified to be Medicaid providers. Fiscal intermediaries will also inform participants of potential providers who have non-excluded convictions on their criminal history screening to assure the participant is fully informed of the potential provider's criminal history before concluding the hiring process.

Supports furnished when the participant exercises budget authority:

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

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

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

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

budget

☐ **Other services and supports**

Specify:

Additional functions/activities:

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

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a) The fiscal intermediary provides monthly budget reports to the waiver agency and participant. The supports coordinator or independent supports broker ensures that performance and integrity of the fiscal intermediary are appropriate and acceptable to the participant through person-centered planning meetings and regular contacts with the participant, and follows up with the participant when budget reports indicate that budgets are more than 10 percent over or under the approved amount.

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

c) Waiver agencies review performance of fiscal intermediares annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

Waiver agencies employ supports coordinators who carry out the waiver agency's responsibility to work with participants through the person-centered planning process. Supports coordinators work with participants to develop a person-centered service plan and an individual budget, to obtain authorization of the budget and the person-centered service plan, and to monitor the person-centered service plan, budget and arrangements made as part of the person-centered service plan. The supports coordinators make sure that participants get the services to which they are entitled and the arrangements are implemented smoothly.

The participant can also obtain an independent supports broker to assist with arranging services and supports, and implementing the arrangements. The independent supports broker advocates for the participant and informs the supports coordinator of the participant's choices to assist the participant in developing and implementing the person-centered service plan.

A variety of supports are furnished for each participant. They are described in (a) above and in E-1(a)-(c).

The entity that furnishes intake and assessment (I&A) is the waiver agency through its supports coordinators. I&A is furnished as part of the person-centered planning process to determine the needs and strengths of the individual. I&A is provided based on needs identified through an assessment or as expressed by the participant or on behalf of the participant by their supports broker, caregivers, representatives, service providers, or informal supports at any time. Secondarily, I&A could be provided by fiscal intermediaries and the allies participating in the person-centered planning process. I&A is assessed as part of the case review process and evaluated through participant satisfaction surveys.

MDHHS does not have a different review process for participants who choose self-determination. During the CQAR process, the EQRO examines each record selected to ensure person-centered service plans are appropriate and payments to providers for services delivered are made in accordance with the approved person-centered service plan. While self-determined participants may use a different funding mechanism, and the CQAR team may have to look at different documentation to verify the appropriateness, the EQRO ensures the appropriateness of budgets, person-centered service plans, and payments within the same protocol used for all other records reviewed.

MDHHS reviews all policies, procedures, and forms used for self-determination as developed and during the AQAR process.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology	☐
Environmental Accessibility Adaptations	☐
Supports Coordination	☒
Training	☐
Goods and Services	☐
Adult Day Health	☐
Personal Emergency Response System	☐
Home Delivered Meals	☐
Counseling	☐
Respite	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supports Brokerage	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Vehicle Modifications	☐
Fiscal Intermediary	☒
Community Transportation	☐
Nursing Services	☐
Community Living Supports	☐
Private Duty Nursing/Respiratory Care	☐
Residential Services	☐
Community Health Worker	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Several options for independent advocacy are available through self-determination. These options include utilizing a network of allies in the person-centered planning process and retaining an independent supports broker for assistance throughout planning and implementation of the person-centered service plan and individual budget. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what works best for the participant, are consistent with his or her needs, and reflect the individual's circumstances. The independent supports broker may assist the participant to explore the availability of community services and supports, assist with access to housing and employment, and assist with making the necessary arrangements to link the participant with those identified supports. Supports brokerage services offer practical skills training to enable individuals to remain independent, including the provision of information on recruiting, hiring and managing workers, effective communication skills, and problem solving. When a participant uses an independent supports broker, the supports coordinator has a more limited role in planning and implementation of services and supports to protect against duplication of services. However, the authority of the supports coordinator in approving the person-centered service plan and individual budget on behalf of the waiver agency is not delegated.

RESPONSE TO IRAI 8/9/2023: DURING THE PERSON-CENTERED PLANNING PROCESS, THE SUPPORTS COORDINATOR ASKS THE PARTICIPANT ABOUT ANY ALLIES THEY WOULD LIKE TO INCLUDE AND INFORM THEM ABOUT THE AVAILABILITY OF A SUPPORTS BROKER IF NEEDED.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The participant may choose to modify or terminate his or her self-determination option at any time. The most effective method for making changes is the person-centered planning process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may be interfering with the success of self-determination. The decision of a participant to terminate participant direction does not alter the services and supports identified in the person-centered service plan. The waiver agency is obligated to assume responsibility for assuring the provision of the services through its network of contracted provider agencies.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A waiver agency may involuntarily terminate a participant's self-determination option when the health and welfare of the participant is in jeopardy or other serious problems are resulting from the participant's inability to or failure in directing services and supports. Before the waiver agency terminates this option, and unless it is not feasible, the waiver agency informs the participant in writing of the issues that have led to the decision to consider altering or discontinuing this option and provides an opportunity for problem resolution. Typically, the person-centered planning process is used to address the issues, with termination being a last resort when other mutually agreeable solutions cannot be found. The waiver agency is responsible to work with the participant to find agency-based providers when revoking the self-determination option. The decision of the waiver agency to terminate participant direction does not alter the services and supports identified in the person-centered service plan. Waiver agencies notify participants that the self-determination option is being rescinded and of their right to file a grievance about this decision. However, if waiting to terminate these arrangements places the participant in jeopardy, the arrangements are terminated immediately and information on how to file a grievance is provided.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		2363
Year 2		2544
Year 3		2591
Year 4		2638
Year 5		2685

Appendix E: Participant Direction of Services

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

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

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

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

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

The guidance on the MI Choice website specifies requirements for the Agency with Choice model. Typically, any agency-based provider who is willing to share employer authority with a participant and enter into a three-way agreement with the participant and employee may be an Agency with Choice provider. Agencies may be included in the waiver agency's provider network or not. When the agency is not included in the provider network, the waiver agency is responsible to assure the provider agency meets all provider requirements. The provider agency may choose to limit the number of Agency with Choice agreements in which they enter with participants and employees.

RESPONSE TO RAI:
THE SELF-DETERMINATION GUIDELINES AVAILABLE HERE:
HTTPS://WWW.MICHIGAN.GOV/MDHHS/ASSISTANCE-PROGRAMS/MEDICAID/PORTALHOME/MEDICAID-PROVIDERS/PROGRAMS/MI-CHOICE-WAIVER-PROGRAM SPECIFY THE FOLLOWING:
THE AGENCY WITH CHOICE (AWC) MODEL SPLITS THE EMPLOYER DUTIES BETWEEN THE AWC PROVIDER AND THE PARTICIPANT. THE AWC PROVIDER SERVES AS EMPLOYER OF RECORD. EMPLOYER OF RECORD IS A TERM THAT DESCRIBES AN AGENCY OR INDIVIDUAL THAT HANDLES THE ADMINISTRATIVE ASPECTS OF BEING AN EMPLOYER (SUCH AS PAYROLL, WITHHOLDING AND PAYING INCOME AND UNEMPLOYMENT TAXES, AND PAYING WORKER'S COMPENSATION INSURANCE). THE PARTICIPANT SERVES AS MANAGING EMPLOYER. IN THE AWC MODEL, THE PARTICIPANT RECRUITS, HIRES, SUPERVISES, AND, IF NECESSARY, FIRES, HIS OR HER OWN WORKER(S). THE AWC AND THE PARTICIPANT ENTER INTO A THREE-PARTY AGREEMENT WITH EACH SUPPORT WORKER THAT EXPLICITLY LAYS OUT THE DUTIES AND RESPONSIBILITIES OF EACH PARTY.

THE THREE-PARTY AGREEMENT IS THE TOOL THAT ENSURES THE INDIVIDUAL MAINTAINS AUTHORITY AND CONTROL OVER THE EMPLOYEES AND TRULY REFLECTS THE KEY ELEMENTS OF SELF-DIRECTION.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

When the MMIS is able to enroll atypical Medicaid providers, all self-determined workers will enroll as an atypical provider in the MMIS and criminal history screenings will occur automatically through that system. MDHHS will incur the cost of these investigations directly.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Fiscal Intermediaries may have their own process, but at a minimum it must include that referenced in Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individual budget is based on the person-centered service plan developed through the person-centered planning process. The budget is created by the participant, the supports coordinator and the independent supports broker, if one is used. Funding must be sufficient to purchase the waiver services and supports identified in the person-centered service plan.

A simple methodology using reliable cost estimating information is used to develop the budget. Each budget is the sum of the units of service multiplied by the period covered, multiplied by the rate for the service as agreed upon by the participant and authorized by the waiver agency. The state does not set a uniform rate for each service. This formula allows each participant and waiver agency to negotiate rates for providers. Typically, when an existing person-centered service plan is transitioned to a participant-directed set of service arrangements, the overall budget is not more than the costs of delivering the services under the previous provider-driven plan.

The document Self Determination in Long Term Care is located on the MDHHS MI Choice webpage and includes mandatory budget forms that each waiver agency uses to consistently create budgets for each participant across the state. The waiver agency does not set rates, although the waiver agency often assists the participants with setting rates by suggesting a range of hourly rates, because participants commonly are not knowledgeable about how to set rates or what an appropriate rate would be. MDHHS also offers and allows participants to have a supports broker assist with the self-determination process, including setting rates and assisting with appeals. Waiver agencies do have authority to approve budgets.

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

The waiver agency authorizes the funds in an individual budget. The supports coordinator must share the cost estimating information with the participant and his or her allies. The target may be exceeded for any individual, but the supports coordinator typically obtains approval from a supervisor within the waiver agency for those higher increments of cost. The waiver agency is responsible for monitoring the implementation of the budget and making adjustments as necessary to ensure that the budget is sufficient to accomplish the plan and maintain the health and welfare of the participant. To this end, the fiscal intermediary provides monthly reports on budget utilization to the participant and the waiver agency. The supports coordinator is expected to review the status of each participant's monthly budget utilization report and confers with the participant as necessary to support success with implementing the person-centered service plan, staying on budget, and obtaining needed services. An independent supports broker may share this task as determined during the planning process and outlined in the person-centered service plan.

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

Guidance provided to participants by waiver agencies:

MDHHS uses a retrospective zero-based method for developing an individual budget. This means the amount of the individual budget is determined by costing out the services and supports in the person-centered service plan, after a person-centered service plan that meets the individual's needs and goals is developed. Budgeting worksheets are provided by MDHHS to uniformly calculate budgets across the state. The participant and the waiver agency agree to the amounts of the individual budget before the waiver agency authorizes it for use by the participant. The waiver agency explores options in terms of preferences as well as costs with the participant with

the aim for arrangements that improve value.

The waiver agency ensures that all waiver participants have a meaningful copy of the person-centered service plan and the individual budget. The waiver agency also ensures the provision of a monthly spending report based on the individual budget and services used. The waiver agency follows up with participants when spending has a variance of 10% above or below the total monthly budget.

The participant and his or her allies are fully involved in the budget development process and the participant understands the options and limitations for using the funds in the individual budget to obtain the services and supports in the person-centered service plan. The supports coordinator informs participants in writing of the options for, and limitations on, flexibility and portability. Waiver agencies must inform participants as to how, when, and what kind of changes they can make to their individual budget without support coordinator approval and when such changes require approval.

Internal Appeal:
The waiver agency would send the participant a Notice of Adverse Benefit Determination if their request for a budget adjustment was denied, reduced, or suspended. The participant has the opportunity to appeal first with the waiver agency.

Fair Hearing Process:

When there is an internal appeal that upholds the decision to deny, reduce or suspend, or the waiver agency does not respond within the required timeframe, the participant would be provided with the Notice of Internal Appeal Decision - Denial Notice and State Fair Hearing rights and the Hearing Request Form. At this time, the participant would be able to file a State Fair Hearing.

These letters, which are reviewed during the MDHHS Administrative Quality Assurance Review, give instructions on how to file an appeal and request a State Fair Hearing by contacting the waiver agency or MDHHS directly. Information on how to file an appeal is also included in the MI Choice Participant Handbook.

Each waiver agency has an internal grievance process that the participant can use.

Public Information:

This information is provided to all MI Choice participants and applicants. Any participant could request the information from the waiver agency at any time. This information is also available in the MI Choice policy chapter in the Medicaid Provider Manual, and also the MI Choice contract and is available on a public MDHHS website: http://egrams-mi.com/dch/User/home.aspx.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the person-centered service plan, using the person-centered planning process. If a participant has an existing person-centered service plan that meets his or her needs, an individual budget to implement the existing plan can be developed through the person-centered planning process. Budget authorization is contingent upon the participant and the waiver agency reaching agreement on the amount of the budget and on the methods to be applied by the participant to implement the person-centered service plan and the individual budget. The budget is provided to the participant in written form as an attachment to the Self-Determination Agreement that outlines the expectations and obligations of the participant and the waiver agency. The participant's person-centered service plan and individual budget is also attached to the agreement.

The supports coordinator provides assistance to the participant in understanding the budget and how to utilize it. In situations where the participant has an independent supports broker, the broker assists the participant in understanding and applying the budget. The participant may seek an adjustment to the individual budget by requesting this from their supports coordinator. The supports coordinator assists the individual in convening a meeting that includes the participants chosen family members and allies, and assures facilitation of a person-centered planning process to review and reconsider the budget. A change in the budget is not effective unless the participant and the waiver agency authorizes the change.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

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

a. Service authorizations allow flexibility across time periods (e.g. month, quarter, etc.) so that participants may schedule providers to meet their needs according to their preferences and individual circumstances. In situations where actual utilization is not exactly the same as initially planned utilization, no notification is necessary on the part of the participant. However, parameters are contained in waiver agency contracts with providers of Fiscal Intermediary services that define ranges of monthly variation outside of what the fiscal intermediary is required to flag for attention and review by the participant and the participants supports coordinator. The participant must be able to shift funds between line items as long as the funding pays for the services and supports identified in the person-centered service plan. Participants may negotiate rates with providers that are different from the rates that the budget is based upon, so long as the participant remains within the overall framework of their respective budgets. These utilization patterns and actual cost differences appear in monthly budget reports provided by the fiscal intermediary. The supports coordinator is expected to review monthly budget reports and interact with the participant to assure that implementation is occurring successfully. When a participant is intending to significantly modify the relative amount of services in comparison to their person-centered service plan, they are expected to inform the fiscal intermediary and the supports coordinator.

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

c. When the participant is not satisfied with the service plan and individual budget that result from the person-centered planning process, the participant may reconvene a person-centered planning meeting, request an internal appeal with the waiver agency, file a fair hearing request if necessary after the internal appeal with the waiver agency, or utilize an informal grievance procedure offered by the waiver agency.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The information below is based on requirements under 42 CFR 438.400...through 42 CFR 438.424.

Adequate Notice
(RESPONSE TO IRAI 8/9/2023) THE WAIVER AGENCY PROVIDES A WRITTEN Adequate Notice to the individual seeking services, allowing immediate access to a State Fair Hearing in the following situations:
- when adding an individual on the waiting list because the waiver agency is at maximum capacity,
- when an individual is not put on the waiting list or assessed because they do not meet criteria according to the MI Choice Intake Guidelines (MIG),
- when an individual does not meet Nursing Facility Level of Care criteria, or
- when an individual does not get enrolled because there is not a need for a MI Choice service.

Advance Notice
(RESPONSE TO IRAI 8/9/2023) THE WAIVER AGENCY PROVIDES A WRITTEN Advance Notice to the participant enrolled in MI Choice but no longer meets nursing facility level of care eligibility. This allows access to a State Fair Hearing since this is MDHHS making NFLOC determinations.

Adverse Benefit Determination Notice
Waiver agencies also use the Adverse Benefit Determination Notice. This allows for the opportunity for internal review with the waiver agency prior to the individual requesting a State Fair Hearing in some situations.
- (RESPONSE TO IRAI 8/9/2023) THE WAIVER AGENCY PROVIDES A WRITTEN NOTICE OF ADVERSE BENEFIT DETERMINATION to the individual when denying a requested service that is not already in place. This is effective on the decision date.
- The Adverse Benefit Determination Notice is also used when terminating, suspending, reducing a service that is in place, and is provided to the participant 10 days before the effective date, unless there is an exception. As long as a request is received before the effective date, services remain in place until the Notice of Resolution is sent to the participant.
- If a determination is being made or action is being taken based upon suspect of fraud, the Adverse Benefit Determination Notice is sent to the individual but may only be sent five days before the effective date.

Notice of Resolution
(RESPONSE TO IRAI 8/9/2023) THE WAIVER AGENCY PROVIDES A WRITTEN NOTICE OF RESOLUTION to inform the participant of the outcome of the internal appeal process when the internal appeal decision is unfavorable to the participant. Information about how to request a State Fair Hearing must also be provided to the individual. Benefits must be continued when:
- Request for State Fair Hearing is received within 10 days of the Notice of Resolution AND
- The participant requests continuation of benefits

The participant may also request a State Fair Hearing if the waiver agency does not send Notice of Resolution for internal appeal within 30 days of written request.

Attachment C of the MI Choice contract with the waiver agencies outlines the additional requirements for appeals and grievances, and aligns with federal regulations. All contracts and amendments are reviewed by CMS.

(RESPONSE TO IRAI 8/9/2023) ALL APPEAL/HEARING NOTIFICATIONS ARE MAINTAINED AT THE WAIVER AGENCY.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution

process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The following describes the second level review criteria for applicants who did not meet the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). At random and whenever indicated, the MDHHS designee will perform reviews to validate the Michigan Medicaid Nursing Facility LOCD.

If an ineligible applicant is issued an Adverse Action notice from the waiver agency based on an LOCD, the applicant has the right to request a hearing using the Medicaid Fair Hearing process. The applicant also has the right to request a Secondary Review through the MDHHS designee. A Secondary Review is not an appeal; it is another medical/functional review. Medicaid pending or Medicaid eligible beneficiaries may contact the MDHHS designee to request a Secondary Review. (RESPONSE TO IRAI 8/9/2023) THE APPLICANT MAY REQUEST A SECONDARY REVIEW WITHIN THREE BUSINESS DAYS FOLLOWING WRITTEN NOTICE OF THE ADVERSE ACTION. LOCATED WITHIN THE ADVERSE ACTION NOTICE IS INFORMATION FOR HOW TO REQUEST A SECONDARY REVIEW. IF THE SECONDARY REVIEW DETERMINES THE INDIVIDUAL IS ELIGIBLE, MDHHS OR ITS DESIGNEE WILL NOTIFY THE WAIVER AGENCY AND THE INDIVIDUAL OR LEGAL REPRESENTATIVE. IF THE SECONDARY REVIEW DETERMINES THAT THE INDIVIDUAL IS INELIGIBLE, AN ADVERSE ACTION NOTICE IS ISSUED AND WILL INFORM THE INDIVIDUAL OF THEIR APPEAL RIGHTS. MDHHS OR ITS DESIGNEE ENTERS THE APPROPRIATE LOCD IN THE CHAMPS LOCD SYSTEM.

A waiver agency may also request a review as part of the Secondary Review. This is available for Medicaid financially pending or Medicaid financially eligible beneficiaries who do not meet medical and functional eligibility based on the web-based Michigan Medicaid Nursing Facility LOCD criteria, but demonstrate a significant level of long term care need.

Upon approval of MDHHS, or its designee, applicants exhibiting the following characteristics and behaviors may be admitted to programs requiring the Nursing Facility Level of Care. An applicant need trigger only one element to be considered for an exception.

Frailty: The applicant has a significant level of frailty as demonstrated by at least one of the following categories:

1. Applicant performs late loss ADLs (bed mobility, toileting, transferring, and eating) independently but requires an unreasonable amount of time.
2. Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.
3. Applicant has experienced at least two falls in the home in the past month.
4. Applicant continues to have difficulties managing medications despite the receipt of medication set-up services.
5. Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services.
6. Applicant meets criteria for Door 3 of the Michigan Medicaid Nursing Facility Level of Care when emergency room visits for clearly unstable conditions are considered.

Behaviors: The applicant has a one month history of any of the following behaviors, and has exhibited two or more of any these behaviors in the last seven days, either singly or in combination:

1. Wandering
2. Verbal or physical abuse
3. Socially inappropriate behavior
4. Resists care

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

This review process does not impact the applicant’s right to access the Medicaid Fair Hearing process. If MDHHS, or its designee, affirms the original determination after the Secondary Review, the applicant is given an Adequate Action Notice to inform them of their right to an administrative hearing.

Each waiver agency also has its own internal complaint process. MDHHS requires the agency to notify all participants of this process. This process cannot replace the MDHHS process, but the participant can pursue both processes at the same time. MDHHS reviews the complaint policies and procedures during the Administrative Quality Assurance Review process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

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

Neglect - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law or rules, policies, guidelines, written directives, procedures, or individual plans of service that cause or contribute to non-serious physical harm or emotional harm, death, or sexual abuse of, serious physical harm to a recipient, or the intentional, knowing or reckless acts of omission or deprivation of essential needs (including medication management).

Physical abuse - The use of unreasonable force on a participant with or without apparent harm. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

Provider no shows - Instances when a provider is scheduled to be at participant home but does not come and back-up service plan is either not put into effect or fails to get an individual to the participant home in a timely manner. This becomes a critical incident when the participant is bed bound or in critical need and is dependent on others.

Sexual abuse - (i) Criminal sexual conduct as defined by sections 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
(ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.

"Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in a sexual manner for any of the following:
(i) Revenge.
(ii) To inflict humiliation.
(iii) Out of anger.
"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Theft - A person intentionally and fraudulently takes personal property of another without permission or consent and with the intent to convert it to the taker's use (including potential sale).

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

Worker consuming drugs or alcohol on the job Use of any drugs or alcohol that would affect the abilities of the worker to do his or her job.

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

Medication errors - Any preventable event that may cause or lead to inappropriate medication use or participant harm as a result of abuse, neglect, or exploitation on the part of a health care professional, family member, direct care worker, informal supports, or the individual. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. Examples of a medication error include giving or taking the wrong medication, wrong dosage, or missed dosage. There is a difference between a

medication error and the individual's adherence to their prescribed medication regimen. Individuals who make an informed choice to not be 100 percent adherent to their prescribed medication regimen are not experiencing a medication error and should not be included as a critical incident.

Suicide - death occurs.

Suicide attempts -- suicide was attempted but no death occurred.

Self-harm - Participant intentionally harms self.

Eviction - involuntary discharge from the home.

Missing person/Elopement -- A participant is missing or wandered away.

Waiver agencies have first line responsibility for identifying, investigating, evaluating and follow-up of critical incidents that occur with participants as listed above. Waiver agencies maintain policies and procedures defining appropriate actions to take upon suspicion or determination of abuse, neglect and exploitation. Waiver agencies establish local reporting procedures, based on MDHHS requirements, for all complaints and critical incidents that jeopardize or potentially jeopardize the health and welfare of participants conveyed and detected by waiver agencies, provider agencies, individual workers, independent supports brokers and participants and their allies. MDHHS reviews and approves these reporting procedures.

Michigan Public Act 519 of 1982 (as amended) mandates that all human service providers and health care professionals make referrals to the MDHHS Adult Protective Services (MDHHS-APS) unit when the professional suspects or believes an adult is being abused, neglected, or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. Waiver agencies also must report suspected financial abuse per the Financial Abuse Act (MI S.B. 378 of 1999). Policies and procedures that waiver agencies develop must include procedures for follow up activities with MDHHS-APS to determine the result of the reported incident and next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect or exploitation, as well as the referral to MDHHS-APS, must be maintained in the participant's case record.

Timeframes are as follows:

Unexplained death, also reported to law enforcement agencies, must be reported to MDHHS within seven calendar days. For all other Critical Incidents, contracted providers must report to the waiver agency within 30 calendar days of the Critical Incident. Once the waiver agency is notified of the Critical Incident, MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within two business days of the waiver agency becoming aware of the incident.

Waiver agencies are responsible under contract for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. Waiver agencies are required to report the type of critical incidents and the responses to those incidents within 30 days of the date of the incident. MDHHS expects to see an attempt at a resolution within 90 days from the date the incident is reported. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Waiver agencies train participants and their families or legal representatives how to identify and report suspected abuse, neglect and exploitation, including who to report incidents to, i.e., waiver agencies, MDHHS-APS, and local law enforcement agencies. The training takes place during face-to-face interviews with participants either during person-centered planning meetings, assessment visits or follow-up meetings. The training is supported by information included in the MI Choice Participant Handbook, which is provided to each participant upon enrollment, and when requested or otherwise indicated thereafter. This training is conducted by supports coordinators initially during enrollment and initial person-centered planning or assessment, and annually thereafter. Training is provided more frequently when there is indication that it may be needed. Participants are also informed that supports coordinators are mandated to report suspected incidents of abuse to the MDHHS-APS and to MDHHS through incident management reports.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Waiver agencies manage critical incidents at the local level. Waiver agencies are responsible to receive reports of critical incidents and assure the immediate health and welfare of the participant. The waiver agency must also make sure to report to the following entities:

Exploitation - Required to report to APS, MDHHS

Neglect - Required to report to APS, MDHHS

Verbal abuse - Required to report to APS, MDHHS

Physical abuse - Required to report to APS, MDHHS

Sexual abuse - Required to report to APS, MDHHS

Theft - MDHHS

Provider no shows, particularly when participant is bed bound all day or there is a critical need - MDHHS

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

Worker consuming drugs/alcohol on the job - MDHHS

Unexplained Death - Death should be reported to law enforcement if it is a suspicious death possibly linked to abuse or neglect. These types of incidents must also be reported to MDHHS within two business days of the waiver agency receiving the notice.

Medication errors - MDHHS

Suicide/suicide attempts/self-harm - MDHHS

Eviction - MDHHS

Missing person/Elopement -- MDHHS

Waiver agencies begin to investigate and evaluate critical incidents with the participant within two business days of identification that an incident occurred. Waiver agencies are expected to investigate a critical incident until the participant is no longer in danger. This may include a removal of the service provider effective the date of the incident or it may involve securing an alternate guardian for the participant, which may take several weeks or months. For this reason, MDHHS does not require cases be resolved within a specific timeframe. Cases are only resolved when the participant's health and welfare is assured to the extent possible given the participant's informed choice for assuming risks. However, MDHHS expects to see an attempt at a resolution within 90 days from the date the incident is reported. If the wavier agency does not appear to be resolving the issue in a timely manner, MDHHS will contact the waiver agency to get additional information and provide assistance in resolving the critical incident when possible. The waiver agency must update the notes frequently until the incident is resolved.

Each waiver agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion of abuse, neglect or exploitation. This includes identifying and evaluating each incident, initiating prevention strategies and interventions approved by participants to reduce or ameliorate further incidents, and follow-up, track, and compile mandatory critical incident reports. The policies and procedures must include procedures for follow-up activities with MDHHS-APS and law enforcement to determine the result of the reported incident and the next steps to be taken if the results are unsatisfactory.

The participant and any chosen family or allies are updated on the investigation as it progresses. Waiver agencies communicate with the participant and family or allies at a minimum of monthly via telephone, but more often as updates or actions occur with the critical incident. Remediation of a critical incident often includes changing services or providers. Supports coordinators use a person-centered planning approach with participants when suggesting and selecting various options to ensure the health and welfare of the participant.

MDHHS evaluates and trends the incident reports submitted by the waiver agencies. Analysis of the strategies employed by the waiver agencies in an attempt to reduce or ameliorate incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. Training is provided to the waiver agencies as necessary to educate staff on abuse and to strengthen preventive interventions and strategies.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

MDHHS is the state agency responsible for oversight of reporting and response to critical incidents.

Waiver agencies are required to input critical incidents into the online Critical Incident Reporting system. All critical incident reports must include location of incident, provider involved (if applicable), reporting person, information about the participant, a description of each incident, action steps, strategies implemented to reduce and prevent future incidents from recurring and follow-up activities conducted through the resolution of each incident. Waiver agencies must initially enter incidents in the system within 30 days of the date of the incident. MDHHS has access to the Critical Incident Reporting system where they can review reports and follow-up with questions or address concerns with the waiver agencies, including questions on missing information or completeness of the report.

It is required that waiver agencies report suspicious or unexpected deaths to MDHHS within seven calendar days. They can notify MDHHS via phone, email or the Critical Incident Reporting system and must follow-up with the formal report due within 30 calendar days of learning about the date of incident.

MDHHS monitors and reviews report submissions. MDHHS reviews, evaluates, and trends individual and summary incident reports submitted by the waiver agencies at a minimum of every quarter. MDHHS reviews reports that involve providers and alert waiver agencies if a trend is discovered so new providers can be secured, if necessary. Analysis of the strategies employed by waiver agencies in an attempt to reduce or prevent incidents from reoccurring is conducted to ensure that adequate precautions and preventative measures were taken. MDHHS verifies that waiver agencies use appropriate related planned services and supportive interventions to prevent future incidents. Training is provided to waiver agencies as necessary to educate staff on abuse and to strengthen preventive interventions and strategies. MDHHS also verifies that waiver agencies report incidents of abuse, neglect and exploitation to the Michigan Department of Health and Human Service Adult Protective Services (MDHHS-APS) as required.

Aggregate reports are created and shared with waiver agencies and with the Quality Management Collaborative to assist in identifying trends or issues that need to be addressed system-wide to prevent or reduce future occurrences.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

MDHHS contracts with an EQRO that has qualified reviewers who conduct annual CQARs and home visits (additional detail about the CQAR is available in Appendix H). The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a critical incident report. If there was not a report, the EQRO would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from occurring again.

Supports coordinators also discuss the waiver program and services with participants during their contacts. Any displeasure communicated at that time is vetted thoroughly and instances of restraint usage are discussed. The supports coordinator will include alternatives to using restraints during the discussion. When a paid provider uses restraints, additional follow-up with the provider is required since Michigan does not allow use of restraints by paid providers.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

MDHHS prohibits providers from using restrictive interventions as part of the provision of waiver services. Lap belts used to keep a person secure in their wheel chair and other restrictive interventions can only be used if a participant requests this intervention through the person-centered planning process and it is clearly documented in the participant's person-centered service plan.

MDHHS contracts with an EQRO that has qualified reviewers to conduct annual CQARs and participant interviews. Part of this process is a discovery process to examine the use of restrictive interventions by family and informal caregivers. The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a critical incident report. If there was not a report, the EQRO would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from happening again. Upon the waiver agency reporting the critical incident in the online database, MDHHS would look for information in the critical incident that addresses ways to prevent this restrictive action from occurring again.

The supports coordinator also discusses the waiver program and services with participants during their contacts. Any displeasure communicated at that time is vetted thoroughly and instances of restrictive interventions are investigated.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

MDHHS prohibits providers from using seclusion as part of the provision of waiver services.

MDHHS contracts with an EQRO that has qualified reviewers to conduct annual CQARs and participant interviews. Part of this process is a discovery process to examine the use of seclusion by family and informal caregivers. The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a report. If there was not a report, The EQRO would consider this a non-evident finding and would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent the lack of reporting from happening again. Upon the waiver agency reporting the critical incident in the online database, MDHHS would look for information in the critical incident that addresses ways to prevent this seclusion from occurring again.

The supports coordinator also discusses the waiver program and services with participants during their contacts. Any displeasure communicated at that time is vetted thoroughly and instances of seclusion are investigated.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Most MI Choice participants live in their own homes, in which case the waiver agencies have ongoing responsibility for second line management and monitoring of participant medication regimens (first line management and monitoring is the responsibility of the prescribing medical professional). As part of the assessment and reassessment (reassessments are conducted 90 days after the initial assessment, with a reassessment occurring annually thereafter, or upon a significant change in the participant's condition), supports coordinators collect complete information about the participant's medications, including what each medication is for, the frequency and dosage. An RN supports coordinator reviews the medication list for potential errors such as duplication, inappropriate dosing, or drug interactions. The RN supports coordinator is also responsible for contacting the physician(s) when there are questions or concerns regarding the participant's medication regimen. Regular supports coordinator monitoring of participants includes general monitoring of the effectiveness of the participant's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with participants, and discussion with direct care and other staff as appropriate.

If a death or injury requiring emergency treatment or hospitalization is the result of a medication error, the waiver agency must follow-up to address the participant's health and welfare as applicable, submit a report via the critical incident reporting system and conduct an investigation. The same is true if a medication error results in the death of a participant with the additional requirement that the waiver agency contact the local authorities for a legal investigation.

Michigan's Department of Licensing and Regulatory Affairs (LARA) licenses and certifies Adult Foster Care and Homes for the Aged. A significant number of MI Choice participants reside in these types of settings. Licensing rules dictate the requirements for medication, including storage, staff training, administration, and the reporting of medication errors. LARA licensing inspections occur every two years, as well as conducting special investigations when needed. These individuals also benefit from additional review of medications by the supports coordinators during assessment and reassessments.

The Michigan Administrative Rule 330.7158 addresses medication administration:
(1) A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
(2) A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
(3) A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
(4) A provider shall review the administration of a psychotropic medication periodically as set forth in the recipient's individual plan of service and based upon the recipient's clinical status.
(5) If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
(6) A provider shall record the administration of all medication in the recipient's clinical record.
(7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.

(IN RESPONSE TO RAI)
SECOND-LINE MONITORING IS CONDUCTED USING THE SAME METHODS REGARDLESS OF THE PARTICIPANT'S DIAGNOSES AND CONDITIONS OR THE TYPE OF MEDICATIONS INCLUDED IN THEIR MEDICATION REGIMEN.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The state requires waiver agencies to report medication errors that required medical follow-up or hospitalization as a critical incident in the Critical Incident Reporting system. The waiver agencies must report these incidents within 30 days and MDHHS reviews those reports. MDHHS also reviews aggregate reports to determine any trends or issues that need to be addressed.

MDHHS is responsible for follow-up and oversight of proper medication management practices. MDHHS contracts an EQRO that employs qualified reviewers who conduct an annual CQAR process to meet CMS requirements for the review of person-centered service plan authorizations and case record reviews. As part of the review, qualified reviewers examine assessment data including the medication list. If any potentially harmful practices are found that were not addressed by supports coordinators, qualified reviewers will report this and a corrective action plan will be required. MDHHS may require the waiver agencies to receive additional technical assistance or training as a result of CQAR and critical incident data.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Administration of medications by waiver providers is subject to the provisions set forth in the service definitions and provider qualifications in Appendix C. All providers administering medications to MI Choice participants are subject to the provisions and limitations established by any licensing parameters established by the State Of Michigan. Residential providers are similarly bound to the rules and regulations established by their licensing requirements.

RESPONSE TO IRAI 8/9/2023:

Each direct service provider who chooses to allow staff to assist participants with self-medication must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum:
• The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant.
• Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.
• Instructions for entering medication information in participant files.
• A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications.

CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:
• A provider must only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
• A provider must ensure that medication use conforms to federal standards and the standards of the medical community.
• A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
• A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status.
• If an participant cannot administer his or her own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
• A provider must record the administration of all medication in participant's clinical record.
• A provider must ensure that staff report medication errors and adverse drug reactions to the participant's physician immediately and properly, and record the incident in the participant's clinical record.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Michigan Department of Health and Human Services

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors that required medical follow-up or hospitalization. "Medication errors" means any preventable event that may cause or lead to inappropriate medication use or participant harm as a result of abuse, neglect, or exploitation on the part of a health care professional, family member, direct care worker, informal supports, or the individual. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. Examples of a medication error include giving or taking the wrong medication, wrong dosage, or missed dosage. There is a difference between a medication error and the individual's adherence to their prescribed medication regimen. Individuals who make an informed choice to not be 100 percent adherent to their prescribed medication regimen are not experiencing a medication error and should not be included as a critical incident. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which consumers have refused medication.

(c) Specify the types of medication errors that providers must *report* to the state:

Medication errors that required medical follow-up or hospitalization. "Medication errors" means any preventable event that may cause or lead to inappropriate medication use or participant harm as a result of abuse, neglect, or exploitation on the part of a health care professional, family member, direct care worker, informal supports, or the individual. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. Examples of a medication error include giving or taking the wrong medication, wrong dosage, or missed dosage. There is a difference between a medication error and the individual's adherence to their prescribed medication regimen. Individuals who make an informed choice to not be 100 percent adherent to their prescribed medication regimen are not experiencing a medication error and should not be included as a critical incident. Providers who administer medications or assist individuals with medications complete an incident report if a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which consumers have refused medication.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The state requires waiver agencies to report medication errors that required medical follow-up or hospitalization as a critical incident in the Critical Incident Reporting system. The waiver agencies must report these incidents within 30 days of learning about the incident and MDHHS is responsible for oversight and reviews each incident. MDHHS reviews aggregate reports to determine any trends or issues that need to be addressed.

MDHHS contracts with an EQRO that employs qualified reviewers who conduct an annual CQAR process to meet CMS requirements for the review of service plan authorizations and case record reviews. As part of the review, qualified reviewers examine assessment data including the medication list. If any potentially harmful practices are found that were not addressed by supports coordinators, qualified reviewers will report this and a corrective action plan will be required. MDHHS may require waiver agencies or service providers to receive additional technical assistance or training as a result of CQAR and critical incident data.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of all critical incidents reported according to policy. Numerator: Number of all critical incidents reported according to policy. Denominator: Total number of all critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of participants or legal guardians who report having received information and education in the prior year. Denominator: Number of participant home visits conducted.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Home visits conducted by EQRO. Home visits conducted on one-half of the representative random sample with CI of +/- 5%.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 90 days. Numerator: Number of critical incidents for which investigations were resolved within 90 days. Denominator: Total number of participant critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of supports coordinators who have completed required training to prevent incidents. Numerator: Number of supports coordinators who have completed required training to prevent incidents. Denominator: All supports coordinators.

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of reported critical incidents that did not involve unauthorized use of restraints, restrictive interventions, or seclusions. Numerator: Number of reported critical incidents that did not involve unauthorized use of restraints, restrictive interventions, or seclusions. Denominator: All critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents that did not include properly reported or followed up on suicide attempts. Numerator: Number of critical incidents that did not include properly reported or followed up on suicide attempts. Denominator: All critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incidents not requiring emergency medical treatment or hospitalization due to medication error. Numerator: Number of critical incidents not requiring emergency medical treatment or hospitalization due to medication error. Denominator: All critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

critical incident reporting database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver). Numerator: Number of participants with an individualized contingency plan for emergencies. Denominator: Number of participant case records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: EQRO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents not reporting hospitalization/ER visit within 30 days of the previous hospitalization due to neglect or abuse. Numerator: Number of critical incidents not reporting hospitalization/ER visit within 30 days of the previous hospitalization due to neglect or abuse. Denominator: All critical incidents.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
critical incident reporting database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Waiver agencies continuously monitor the health and welfare of participants and initiate remedial actions when appropriate. The state identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation on an ongoing basis.

Additional Strategies

1) Waiver agencies conduct risk management (RM) planning with participants during person-centered planning. RM planning includes strategies and methods for addressing health and welfare issues. Supports coordinators negotiate RM with the participant through the person-centered planning process. Supports coordinators and participants monitor and evaluate the effectiveness of RM plans, i.e., which strategies work and which do not work effectively with that given participant. RM planning and updates occur at reassessment or more frequently as needed. Supports coordinators document RM planning in the person-centered service plan.

2) The EQRO verifies that RM planning is occurring during the CQARs conducted annually. The EQRO report includes findings in written monitoring reports, with corrective actions and training as needed. MDHHS, waiver agencies and the Quality Management Collaboration review reports.

3) Waiver agencies train participants, workers, staff, and supports brokers on how to report abuse, neglect, and exploitation. Technical assistance and training records include attendance by date and total number of attendees, topic and content, and training evaluations.

4) Waiver agencies use Quality Indicators (QI) extracted via a report from their assessment data base to measure 20 Participant Health Status Outcomes. Two Quality Indicators address abuse and neglect. The first is Prevalence of neglect/abuse. The numerator for this indicator is the number of clients who have unexplained injuries or have been abused or neglected. The denominator is all clients. The second is the Prevalence of any injuries. The numerator for this indicator is the number of clients with fractures or unexplained injuries. The denominator is all clients. The waiver agencies can examine records for participants scoring into either of these quality indicators to assure that the participant's person-centered service plan contains interventions for the indicator, including methods to prevent future occurrences. Waiver agency staff runs and monitors the reports quarterly. MDHHS has access to these reports for review and analysis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The waiver agency periodically examines Quality Indicator (QI) reports. For each QI, waiver agency staff obtains a list of participants who scored into that indicator. Waiver agency staff can then drill down to determine the reason that each participant scored into the specific indicator and whether or not supports coordinators included appropriate interventions for the identified issue on the person-centered service plan. Waiver agency staff initiates corrective actions as needed after the thorough examination of the data.

MDHHS reviews critical incident reports at a minimum of annually. During this review, MDHHS reviews the data to ensure investigations were started and reports were submitted within the required timeframes. If during the review any critical incidents were discovered to not be investigated within required timeframes, the waiver agency must begin investigation within two business days of the finding. If an investigation had already been started but not in a timely manner, the waiver agency must include information in their corrective action plan that will explain how they will ensure future critical incidents are investigated timely. The waiver agency must also follow-up with MDHHS as the investigation of the specific incident is conducted.

If any critical incidents are found to have not been reported within required timeframes, the waiver agency must submit reports for those critical incidents within two weeks. If any critical incident was reported but not within required timeframes, the waiver agency must include information in the corrective action plan that will explain how they will ensure future reports are submitted timely.

During the CQAR, qualified reviewers conduct participant interviews with a sample of participants from each waiver agency. If during those interviews any participants or legal guardians report not receiving information and education on how to report abuse, neglect, exploitation and other critical incidents, information and education must be provided to those participants or guardians within two weeks, and documentation proving this information has been provided must be submitted to MDHHS and kept in the participant record.

Qualified reviewers examine a sample of participant files and look for individualized contingency plans for emergencies. If any participants are missing these plans, the waiver agency will be required to develop a contingency plan within two weeks and then must provide a copy of the contingency plan to the participant, to MDHHS, and keep one copy in the participant's record.

The EQRO reviews a representative sample of case records during the CQAR. If a reviewer finds any situations that would classify as a critical incident or use of restraints, seclusions or restrictive interventions in the file, they will confirm to see if the waiver agency submitted a report. If there was not a report, the EQRO would consider this a non-evident finding that would require an immediate corrective action to address the specific critical incident identified, as well as a plan to prevent future occurrences of the critical incident and development of methods to assure timely reporting in the future.

Unexplained death, also reported to law enforcement agencies, must be reported to MDHHS within seven calendar days. For all other Critical Incidents, contracted providers must report to the waiver agency within 30 calendar days of the Critical Incident. Once the waiver agency is notified of the Critical Incident, MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within two business days of the waiver agency becoming aware of the incident. The critical incident report must include all information about how the incident was investigated and how it is being followed up on. The waiver agency must update MDHHS as the investigation continues. The corrective action plan must also describe how the waiver agency will prevent the lack of reporting from happening again.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☒ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: waiver agency, EQRO	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

MDHHS designed this strategy to assess and improve the quality of services and supports managed by the waiver agencies. MDHHS is the Single State Agency responsible for establishing the components of the quality improvement strategy. The quality improvement strategy (QIS) includes using several tools to gather data and measure individual and system performance. Tools utilized in this plan include the MDHHS quality assurance and performance improvement (QAPI), waiver agency-specific QAPIs, Clinical Quality Assurance Review (CQAR), Administrative Quality Assurance Review (AQAR), and Critical Incident Reporting (CIR) system.

Michigan developed its QIS with contributions from participants and other stakeholders in collaboration with MDHHS and the waiver agencies. A leadership group composed of participants and advocates and waiver agency staff provides support as the MI Choice Quality Management Collaboration (QMC). The purpose of the QMC is to include participants and advocates in the development and review of MI Choice quality management activities. The QMC provides a venue where participants, advocates and providers can review quality outcomes, identify areas that need improvement, develop strategies for remediation of service delivery, and recommend improvements. Waiver agencies are required to hold their own local quality collaborative meetings quarterly at a minimum.
MDHHS establishes a Quality Assurance and Performance Improvement (QAPI) biennially, which includes statewide goals and strategies identified in part by the consumer-run Quality Management Collaborative. The QAPI focuses on meeting CMS assurances and requirements for protecting the health and welfare of waiver participants, MDHHS contract requirements, and targeted participant outcome improvement goals, and overall program quality. MDHHS requires each waiver agency to have its own QAPI and reviews them biennially. MDHHS guides, prompts, and assists each waiver agency in preparing and updating its QAPI based on individual agency and provider network results from compliance reviews, participant outcomes, consumer survey results, complaint history, and other performance-based outcomes. Each waiver agency includes the MDHHS required goals in its QAPI and adds its own unique quality improvement goals, or self-targeted quality improvement strategies, including service provider performance requirements and administrative improvements. Performance Improvement Projects include both clinical and nonclinical aspects of the program. An Outcomes and Activities report is compiled and submitted to MDHHS on an annual basis summarizing the annual outcomes, activities, and progress of the QAPI each year.

MDHHS developed protocols for the CQAR and AQAR with input from the QMC, advocates, Area Agency on Aging Association, the Michigan Disability Resource Center (MDRC), and other stakeholders. MDHHS updates the protocols annually to incorporate general improvements, policy changes, CMS initiatives, and MDHHS priorities. The CQAR includes a participant interview protocol. A scoring system allows EQRO staff to calculate compliance equitably for each waiver agency regardless of sample size.

The AQAR process includes an examination of policy and procedure manuals, provider monitoring reports, provider contract templates, financial systems, encounter data accuracy, quality assurance and performance improvement plans (QAPI) and verification of required provider licensure to assure that each waiver agency meets all requirements. The AQAR also verifies the waiver agency meets administrative, program policy, and procedural requirements by ensuring maintenance of program records for ten years, controlled access to program records according to HIPAA requirements, waiver agency employee access to program policies and procedures, and proper accounting procedures. MDHHS reviews waiver agency agreements with subcontracted providers, performs provider reviews, and may conduct interviews with both supports coordinators and MI Choice participants. The AQAR is completed for each waiver agency once every five years unless significant issues are discovered. The frequency is based on AQAR scores (percentage of compliance):
86-100 percent, reviewed every five years
80-85 percent, reviewed every four years
70-79 percent, reviewed every three years
Less than 70 percent, reviewed every two years

MDHHS contracts with an EQRO that employs qualified reviewers who conduct the annual CQAR and evaluate the waiver agency’s enrollment, assessment, level of care evaluations, care planning, and reassessment activities seeking evidence of compliance to the CQAR standards and MDHHS MI Choice policy and contract requirements. The reviewers collect and review both qualitative and objective data and evaluate the participant assessments and supports coordinators’ actions to ensure that the person-centered service plans include every participant need identified in the assessments or by the participant. The reviewers determine the waiver agency’s level of compliance to the standards included in the protocol. The qualified reviewers send an initial report of all

non-evident findings and a listing of any findings that require immediate remediation. Any findings related to the health and welfare of an enrolled participant would require remediation within two weeks. Waiver agencies also must provide any additional documentation to rebut non-evident findings within two weeks. Additional documentation is reviewed and some scores may be revised if documentation was overlooked or missing during the initial review. The qualified reviewers then compile the data from the CQAR and issue final reports to the waiver agency within 30 days of the receipt of the additional information. The EQRO sends each final CQAR report, which includes a summary of deficiencies. The EQRO divides the deficiencies into citations and recommendations based upon algorithms for each standard. The waiver agency has 30 days to respond to the citations with a corrective action plan. The corrective action plan may also include actions to address recommendations, but this is not mandatory. The EQRO works with the waiver agency to assure the corrective action plan will produce quality improvements. Once the waiver agency and the EQRO agree on the final corrective action plan, the EQRO sends approval to the waiver agency.

Corrective action plans for CQAR and AQAR should demonstrate that the waiver agency has:
1. Analyzed all non-evident findings and determined possible causes;
2. Developed a remediation strategy, including timelines, that address and resolve the problems;
3. Identified a quality improvement goal for the remediation strategy; and
4. Planned ongoing monitoring of remediation activities to assure improved performance.

Waiver agencies must provide evidence of their remediation strategy by submitting documentation to the EQRO. This documentation might include training materials, revised policies and procedures, information from staff meetings, methods for monitoring improvements, results of monitoring, or case record documentation to support the corrective action plan. The EQRO reviews, then either approves the corrective action plan or works with waiver agency to amend the plan to assure the plan leads to desired outcomes and improvements. The EQRO monitors the implementation of each corrective action plan item to assure that the waiver agency meets established timelines for implementing corrective action. The EQRO notifies MDHHS of all activities to assure compliance to requirements. When waiver agencies update policies and procedures, the EQRO forwards these to MDHHS staff for review and approval.

MDHHS developed the CIR system with assistance from the QMC and other stakeholders. MDHHS requires each waiver agency to report all critical incidents in the web-based CIR System. MDHHS defines procedures for reporting critical incidents in the MI Choice policy chapter in the Medicaid Provider Manual. Waiver agencies manage critical incidents at the local level by identifying, investigating and evaluating each incident. Supports coordinators initiate strategies and interventions approved by participants to prevent further incidents and follow-up, track, and compile mandatory critical incident reports.

MDHHS conducts a review, compiles a summary report, and trends and analyzes report submissions for review annually. The review includes an evaluation of individual and summary reports, investigation and reporting timeliness, the prevention strategies and interventions used, and verification that waiver agency staff reports incidents of abuse, neglect, and exploitation to the MDHHS APS as required. MDHHS provides technical assistance and training as necessary to improve reports and quality outcomes for the participants involved and checks that the waiver agency used appropriate related planned services and supportive interventions to reduce or ameliorate further incidents.

Waiver agencies are required to submit encounter data to MDHHS on a submission schedule set by MDHHS. These encounters include data about services provided and service costs. MDHHS compiles this data into reports to analyze the effectiveness of services and costs and to assist the actuary in setting rates.

During each contract year, MDHHS will withhold a portion of the approved capitation payment from each waiver agency, a one-percent quality withhold. These funds will be used for the waiver agency performance bonus incentive. This incentive will be given to waiver agencies according to criteria established by MDHHS. The criteria will include assessment of performance in quality of care and administrative functions. Each year, MDHHS will establish and communicate to the waiver agencies the criteria and standards to be used for the performance bonus incentives, and this information is outlined in the MI Choice contract.

Additional QIS Activities

1) Waiver agencies conduct risk management (RM) planning with participants during person-centered planning. RM planning includes strategies and methods for addressing health and welfare issues negotiated with the participant. Supports coordinators and participants monitor and evaluate effectiveness of RM plans, noting successful strategies and modifying unsuccessful strategies with the participant. RM planning and updates occur during reassessment or more frequently, if needed. Supports coordinators document RM planning in the service plan.
2) Waiver agencies train participants, workers, staff, and supports brokers on how to report abuse, neglect, and exploitation. Technical assistance and training records include attendance by date and total number of attendees, topic, content, and training evaluations.
3) Waiver agencies monitor service providers annually. Waiver agencies compile provider monitoring reports of provider performance, corrective actions, trainings, and follow-up activities conducted, as necessary. Waiver agencies submit provider monitoring schedules to MDHHS annually and all provider monitoring reports to MDHHS upon completion. MDHHS reviews the waiver agency provider monitoring schedules and administrative monitoring reviews, results, and findings as submitted on an on-going basis. MDHHS also requires the waiver agency to conduct in home participant visits to gauge the effectiveness of service delivery. The waiver agency reviewer is required to conduct two home visits with waiver participants per provider reviewed to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned.
4) MDHHS monitors administrative hearings and decisions as they occur.
5) MDHHS contracts with a third party vendor to conduct the CAHPS for HCBS with participants.
6) Quality indicators for monitoring performance

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: Waiver agencies, EQRO	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Waiver agency QAPI and Quality Indicator data

MDHHS compiles data from waiver agency quality assurance and performance improvement (QAPI) and quality indicator (QI) reports and disseminates the information to QMC members, waiver agency staff and other stakeholders annually. This information includes statewide averages for each QI in the MDHHS QAPI, individual waiver agency QI data, and progress in meeting established benchmarks. MDHHS presents this information at QMC meetings, waiver director meetings, and as requested by other audiences.

AQAR
MDHHS shares individual waiver agency AQAR scores and aggregated data with QMC members, waiver agency staff, and other interested parties. The aggregated report includes the percentage of compliance found for each standard in the AQAR, summarized compliance for each section of the AQAR, and an overall compliance score. MDHHS usually presents this data at QMC and waiver director meetings. The presentation includes a summary of successes in practice, noted deficiencies, and improvements from previous data. MDHHS may also discuss methods utilized to improve compliance and common reasons for deficiencies.

CQAR/Participant Interviews
The EQRO shares individual waiver agency CQAR scores and aggregated data with MDHHS, QMC members, waiver agency staff, and other interested parties annually. The aggregated report includes the percentage of compliance found for each standard in the CQAR, including the participant interviews, summarized compliance for each section of the CQAR, and an overall compliance score. The EQRO usually presents this data at QMC and waiver director meetings. The presentation includes a summary of successes in practice, noted deficiencies, and improvements from previous data. The discussion may also include methods utilized to improve compliance and common reasons for deficiencies.

CIR Reports
Annually, MDHHS analyzes critical incident data including the number of incidents, data trends, remediation methods, and incident resolutions. MDHHS monitors reported incidents that did not include a resolution until the waiver agency finalizes interventions to the satisfaction of the participant involved. MDHHS presents the CIR report to the QMC annually.

Participant Satisfaction Reports - CAHPS HCBS Survey
MDHHS shares the data from the participant satisfaction reports with waiver agencies, QMC members and other interested parties.

MI Choice Quality Website
MDHHS has developed a MI Choice Quality Website. The website includes a summary of the following information for each waiver agency:
• Results from the last two years of CQAR reports, including the compliance determination
• Accreditation status (organization, type, and expiration date)
• Results from CAHPS survey

Links to each report are available on the website. MDHHS will continue to enhance this website as needed.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QMC reviews the QAPI and decides which QIs to include in it biennially. During the review, QMC members discuss current methods, QIs, and benchmarks. Members reach consensus regarding which QIs to include and whether MDHHS should raise or lower benchmarks based on previous results. MDHHS incorporates this advice into the revised QAPI. In turn, each waiver agency incorporates the revised requirements into its own QAPI.

MDHHS updates service standards and contract requirements, as needed, to assure the health and welfare of MI Choice participants and maintain compliance to state and federal requirements. MI Choice policy and contract requirements include the person-centered planning guidelines, supports coordination and service performance standards, and waiver program operating criteria, reporting requirements, waiver agency provider monitoring plan, and billing procedures and coding systems.

MDHHS convenes a workgroup to revise the MI Choice Site Review Protocol (MICSRP) biennially or more frequently, if needed. The workgroup incorporates new standards, deletes ineffective and duplicative standards, and revises wording to clarify standard requirements. MDHHS distributes draft copies to all interested stakeholders for review and comment before finalizing the revision.

MDHHS compiles AQAR and CQAR data to identify common deficiencies on an ongoing basis. When warranted, MDHHS or other appropriate experts provide training to waiver agency staff to clarify issues and improve compliance to the MICSRP. MDHHS works closely with each waiver agency to target training sessions to meet the needs of its staff. Training may consist of formal presentations provided to staff of all waiver agencies, targeted on site sessions for a few waiver agencies with similar problems, teleconferences, clarifying memos, or informal discussions to clarify policy interpretations, improve procedures, or otherwise remove barriers to compliance.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ◉ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) Independent Audit Requirements of Provider Agencies

Provider agencies (including waiver agencies) are required to submit a Single Audit, Financial Statement Audit, Financial Related Audit or Audit Exemption Status Notification Letter to the Department as described below. Provider agencies must also submit a corrective action plan in accordance with 2 CFR §200.511(c) for any audit finding that impacts the program and management letter (if issued) with a response.

1. Single Audit
Provider agencies that are a state, local government or non-profit organization that expend $750,000 or more in federal awards during the contractor's fiscal year must submit a Single Audit to the Department, regardless of the amount of funding received from MDHHS. The Single Audit must comply with the requirements of 2 CFR Subpart F and include all components described in 2 CFR §200.512(c).

2. Financial Related Audit
Provider Agencies that are for-profit organizations that expend $750,000 or more in federal awards during the Grantee's fiscal year must submit either a financial related audit prepared in accordance with Government Auditing Standards relating to all federal
awards; or an audit that meets the requirements contained in 2 CFR, Subpart F, if required by the federal awarding agency.

3. Audit Exemption Notice
Provider agencies exempt from the Single Audit and Financial Related Audit requirements must submit an Audit Exemption Notice that certifies these exemptions.

4. Financial Statement Audit
Provider agencies exempt from the Single Audit and Financial Related Audit requirements (that are required to submit an Audit Exemption Notice as described above) must also submit to the Department a Financial Statement Audit prepared in accordance with generally accepted auditing standards if the audit includes disclosures that may negatively impacts the Department funded programs including, but not limited to fraud, going concern uncertainties, financial statement misstatements, and violations of contract and grant provisions. If submitting a Financial Statement Audit, Grantees must also submit a corrective action plan for any audit findings that impacts the Department funded programs.

The required audit and any other required submissions (i.e. corrective action plan and management letter with a response), or audit Status Notification Letter must be submitted to MDHHS within nine months after the end of the contractor's fiscal year by e-mail to MDHHS.

(b) Financial Audit Program to Insure Provider Billing Integrity

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to waiver agencies. The 834 process generates an enrollment file based upon the PAHP provider ID number and the beneficiary's assignment to the MI Choice Managed Care benefit plan. This process uses edits to assure only the PAHPs that have a contract with the State are provided the capitation payment for the MI Choice program. Each PAHP has a unique state-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to a contracted PAHP. This process includes verifying the participant's Medicaid eligibility and nursing facility level of care evaluation. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PAHP using the Medicaid Management Information System (MMIS). MDHHS utilizes a six month retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 process.

The repayment and recoupment processes are for the capture and correction of funds for beneficiaries who enrolled or disenrolled in the PAHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the MI Choice Waiver program during a given month when the PAHP did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for beneficiaries who disenrolled from the MI Choice Waiver program but the PAHPs received capitation payments due to data lags in the 834 process.

A second form of monitoring is that all waiver service providers contracting with a waiver agency must submit bills to the waiver agency detailing the date of service, type of service, unit cost, and the number of units provided for each waiver participant served. Provider bills are then matched and verified against the participant's approved person-centered service

plan by the waiver agency prior to submitting encounter data to MMIS. The waiver agencies process payments for all verified encounters by the providers.

Providers operating as a waiver agency are required to maintain all participants' records, including assessment, service plans, service logs, reassessments, and quality assurance records for a period of not less than ten years to support an audit trail. MDHHS, providers, and the waiver agencies all maintain records for ten years to allow for full auditing of payments for waiver services.

(c) Agencies Responsible for Conducting the Financial Audit Program

The Michigan Office of the Auditor General (OAG) performs the Medicaid Cluster major federal program compliance review as part of the MDHHS Single Audit. Within this review, expenditures of the MI Choice waiver are included in the Medicaid Cluster population and are subjected to statistical sample testing. Expenditures of the MI Choice waiver were selected and reviewed in the most recent Single Audit for federal compliance requirements and will continue to be subjected to future sample testing.

Additional Information:
The waiver agencies have first line responsibility to ensure services they are paying for were delivered as appropriate and do meet the participant's needs. Also, during CQAR and AQAR, MDHHS or its designees review sources of information to determine if services were rendered.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of person-centered service plans that supported paid services.
Numerator: Number of person-centered service plans that supported paid services.
Denominator: Number of person-centered service plans reviewed.

Data Source *(Select one):*
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+/- 5%*
☒ ***Other*** *Specify:* *EQRO*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *EQRO*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of encounters submitted to MDHHS within required timeframes.
Numerator: Number of encounters submitted to MDHHS within required timeframes.
Denominator: Number of encounters submitted to MDHHS.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *Waiver agency*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the waiver agencies for MI Choice participants with active Medicaid. Denominator: Total number of all MI Choice capitation payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample***

		Confidence Interval =
☒ ***Other*** *Specify:* *CHAMPS, MDHHS Data Warehouse*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of encounters submitted to MDHHS with all required data

elements. Numerator: Number of encounters submitted to MDHHS with all required data elements. Denominator: Number of all encounters submitted to MDHHS.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Online database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *Waiver agency*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of capitation payments that have been paid at rates approved by the Actuary. Numerator: Number of capitation payments that have been paid at rates approved by the Actuary. Denominator: All capitation rates paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS data for capitation payments

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative***

		Sample *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the*

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Financial Monitoring and Audit

MDHHS requires waiver agencies to conduct annual financial monitoring according to the waiver agencies' MI Choice Waiver Program Provider Monitoring Plan. This methodology is designed to ensure and verify that:

1) Direct service providers comply with minimum service standards and conditions of participation in the Medicaid program;

2) Providers deliver services according to the MI Choice participant person-centered service plan;

3) Providers maintain an adequate number of trained staff through recruitment, training, and staff supervision and support; and

4) Providers maintain participant case record documentation to support encounter data.

Waiver agency staff reviews, evaluates, and compares service provider records to work orders, service plans, service claims, and reimbursements. Waiver agency staff compares payment records to MI Choice service plan authorization (work orders) and other waiver agency service documentation to ensure they match. Waiver agency staff evaluates provider records for date of service, time of service delivery, staff providing the service, and supervision of staff providing services, notes any discrepancies during the review and includes them in written findings. The waiver agency staff provides written findings of the review and corrective action requirements (as necessary) to the provider within thirty days following completion of the initial review. The waiver agency submits provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. MDHHS reviews and evaluates these reports for completeness and integrity of the process.

MDHHS also requires the waiver agencies to conduct participant home visits to gauge accurately the effectiveness of service delivery. The waiver agency reviewer conducts a minimum of two home visits with participants per provider reviewed to determine participant satisfaction with supports coordination and services and to verify that providers deliver services as planned. MDHHS reviews all waiver agency provider monitoring reports either as completed and submitted to MDHHS.

Additionally, MDHHS conducts reviews to verify the waiver agency maintains administrative and financial accountability. MDHHS conducts financial reviews of waiver agencies during the AQAR process. MDHHS reviews and evaluates a sample of participant claims from the person-centered service plan during a three-month period. This process includes reviewing the service record from inception through reported encounter data to verify that records match by date of service, amount, duration, and type of service.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

When the waiver agency reviews the provider agency, the waiver agency written review includes citations of both positive findings and areas needing corrective action. It is the waiver agency's responsibility to monitor a provider's performance in completing the necessary corrective actions. Waiver agencies may suspend new referrals to a provider agency and transfer participants to another provider when findings warrant immediate action to protect a participant's health and welfare. Waiver agencies make provider billing adjustments on the computerized client tracking system to the Medicaid Management Information System (MMIS) using individual encounter adjustment to date of service or through gross adjustment methodology. The waiver agency deducts over payments made to a provider from the next warrant issued and due the provider from the waiver agency. The waiver agency may suspend or terminate a provider who demonstrates a failure to correct deficiencies following subsequent reviews. The waiver agency may reinstate providers after verifying that the provider has corrected deficiencies and changed procedural practices as required.

After completing the AQAR, MDHHS conducts exit interviews with the waiver agency staff. During these exit interviews, the waiver agency is provided with a report of all non-evident findings and a listing of any findings that require immediate remediation. The immediate remediation is typically due within two weeks. MDHHS also compiles AQAR findings into reports that are sent to the waiver agency. When these reports indicate a need for corrective action, the waiver agency has 30 days to respond with a corrective action plan.

Corrective action plans should demonstrate that the waiver agency has:
1. *Analyzed all non-evident findings and determined possible causes;*
2. *Developed a remediation strategy, including timelines, that address and resolve the problems; and*
3. *Planned ongoing monitoring of remediation activities and performance.*

Waiver agencies are required to provide evidence of their remediation strategy by submitting documentation to MDHHS. This documentation might include training materials, revised policies and procedures, information from staff meetings or case record documentation to support the corrective action plan. MDHHS reviews, then either approves the corrective action plan and documentation or works with waiver agency staff to amend the plan to meet MDHHS requirements. MDHHS monitors the implementation of each corrective action plan item to assure the waiver agency meets established timelines for implementing corrective action.

Specific remediation steps to be taken for each performance measure in Financial Accountability:

If any provider bills are paid for individuals who are not waiver participants:
1. Waiver agencies must recover payments made for services rendered for individuals who were not waiver participants. Provider billing adjustments can be made in MMIS using individual encounter adjustment to date of service or through gross adjustment methodology.

2. MDHHS utilizes MMIS edits to ensure capitation payments are paid for participants of the waiver program only and will not generate capitation payments for non-eligible individuals.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *waiver agency, EQRO*	☒ ***Annually***
	☒ ***Continuously and Ongoing***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Capitation Rate Development

PAHPs are provided a monthly capitation rate for all enrolled participants. The rates conform to the managed care regulations found at 42 CFR § 438 and payments of the rates are contingent upon CMS approval. The following lists the steps taken to develop the capitation rates.

• Summarize direct services base period data;
• Application of trend year;
• Adjust for Supports Coordination/Case Management;
• Apply administration load; and,
• Withhold percentage (1 percent).

Summary of Base Period Data

Milliman collected historical experience and capitation payments made. Corresponding enrollment records were summarized for the same incurred period. The MI Choice beneficiaries were split by age and Significant Support Participant (SSP) status for comparison.

A list of beneficiaries identified as Significant Support Participants was provided by MDHHS for purposes of rate development. These beneficiaries represent a population that requires a higher need for services and supports than those classified as non-SSP. Typically, these beneficiaries are those that were previously placed in a nursing facility, but have transitioned into a home or community setting.

Based on the list of services covered by the waiver, services were summarized into different categories. The HCPCS or procedure code included on the claim/encounter was used to assign the experience to a service category. The historical experience was converted to a per member per month (PMPM) basis and summarized into actuarial cost models.

Each waiver agency uses an open bid process to contract with qualified providers in their service area that are willing to furnish MI Choice services. MDHHS requires each waiver agency to have a provider network with capacity to serve at least 125% of its expected utilization for each MI Choice service, and at least two providers for each MI Choice service. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from MDHHS. This assures network capacity as well as choice of providers.

RESPONSE TO INITIAL ANALYSIS REPORT: MI Choice does not set specific rates for services provided through the self-direction model. Individual budgets are set based on discussions between the participant and supports coordinator during the person-centered planning process. The rates paid to providers may vary based on participant choice within the limits of the individual budget.

MI Choice capitation rates are developed and certified by the actuary annually. Rates are updated and certified through the State Fiscal Year as needed. All capitation rates are included in the MI Choice contract and submitted to CMS for review and approval annually and as updates are made.

MI Choice capitation rates and rates paid to providers are available to participants upon request to MDHHS or the waiver agencies.

(IN RESPONSE TO RAI)
MDHHS DOES NOT HAVE A RATE SETTING METHODOLOGY FOR SELF-DIRECTED SERVICES SINCE RATES ARE DEVELOPED USING PERSON-CENTERED PLANNING FOR EACH PARTICIPANT. THIS PROCESS IS DESCRIBED IN LENGTH IN APPENDIX E. MDHHS USES AN ACTUARY TO SET THE CAPITATION RATES FOR THIS MANAGED CARE PROGRAM ANNUALLY. THE ACTUARY DEVELOPS REPORTS BASED UPON DATA AND SUBMITS A DETAILED RATE REPORT TO CMS EACH YEAR. MDHHS HAS ANNUAL RATE MEETINGS WITH WAIVER AGENCIES AND THE ACTUARY TO DESCRIBE THE CAPITATED RATE DEVELOPMENT PROCESS AND SOLICIT COMMENTS ON HOW THE RATES WERE DEVELOPED.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers of waiver services bill the waiver agency for services furnished as authorized in the person-centered service plan, and according to the contract between the waiver agency and the provider. Each waiver agency reviews the bills submitted by provider agencies to assure that all claims for services have been rendered in compliance with the approved person-centered service plan. Waiver agencies pay the rendering provider directly once verification for the provision of service in accordance with the approved person-centered service plan is done. The State's capitation payments made to the PAHPs are in accordance with the managed care contracts and the 1915(b) waiver.

In the self-determination option, workers submit timesheets to the fiscal intermediary who, in turn, submits bills to the waiver agency for reimbursement. The waiver agency reimburses the fiscal intermediary according to the process identified in the contract between the fiscal intermediary and the waiver agency. Worker timesheets must be signed by both the worker and the participant or the participant's authorized representative. The fiscal intermediary then pays the self-determination worker based upon the work reported on the time sheet. The fiscal intermediary submits monthly budget reports to both the waiver agency and the participant. Waiver agencies cost settle with fiscal intermediaries on a monthly or annual basis, according to the terms of their mutual contract.

Waiver agencies submit encounter data to the MMIS system based upon bills paid to providers for traditionally arranged service provision and through the fiscal intermediary services supported through the self-determination option, according to the requirements of the managed care contracts and the §1915(b) waiver.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a) When the individual is eligible for Medicaid waiver payment on the date of service.

The 820 Premium Payment process is designed to assure the MI Choice capitation payment is only generated for persons enrolled in the MI Choice benefit plan. To enroll in the MI Choice benefit plan, persons must be deemed eligible for MI Choice and enrolled. The 820 payment process also verifies the beneficiary has a valid Level of Care Determination in the system that indicates the person meets nursing facility level of care criteria. These checks are made before the payment to the PAHP is generated. MDHHS also employs a recoupment and repayment process with a six-month look back period to make adjustments to capitation payments made as eligibility and enrollment information is updated.

PAHPs verify participant eligibility for all dates of service billed by the rendering providers prior to paying provider bills for MI Choice services delivered. When the PAHP finds a provider bill for a date of service when the participant was not eligible, the PAHP either does not pay this bill, or uses alternate funding sources. The PAHP will not submit encounter data for dates of service in which the participant was not eligible. MDHHS requires the PAHP to modify encounter data as necessary so that it only reflects encounters for participants eligible for MI Choice on the dates of service claimed.

b) When the service was included in the participant's approved person-centered service plan.

The waiver agency is responsible for assuring that only services authorized in a participant's person-centered service plan are submitted as encounter data. The waiver agency utilizes their information system to compare bills submitted by provider agencies for authorized waiver services in each participant's person-centered service plan. Only those services contained within the approved person-centered service plan are paid. Claims paid by the waiver agency to the provider agency are then submitted to MMIS as encounter data. The MMIS will only accept encounter data for dates of service for which the participant was eligible for MI Choice enrollment.

MDHHS verifies participant eligibility against dates of service during the AQAR and during the CQAR processes. The AQAR process specifically compares dates of service with eligibility dates for a selected sample of MI Choice participants at each waiver agency. The CQAR process will identify inaccuracies between dates of service and participant eligibility during the course of the case record review and will provide for additional examination as needed if inaccuracies are found in the case record.

c) When the services were provided.

Each waiver agency periodically monitors service provider agencies. This monitoring includes an audit of the paid services compared to documentation including in-home logs kept by paid caregivers, time sheets, and other source documents. Additionally, waiver agencies have systems for participants and service provider agencies to notify the supports coordinator when services are not delivered as planned. Any services reported as not delivered will not be paid during the remit process. Verification of the provider no-show rate is part of the overall quality assurance and performance improvement (QAPI). Waiver agencies have methods within their respective information systems to track services not provided.

MDHHS requires waiver agencies and providers of service to maintain all records for a period of not less than ten years.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

At the end of each month, MDHHS will run the 834 Enrollment file for each waiver agency. This file contains an electronic listing of persons who are enrolled in the MI Choice program with each provider. MMIS then performs quality checks including: verification of current Medicaid eligibility; a valid LOCD indicating the participant meets nursing facility level of care; and the participant is not enrolled in any other long term care program. On the 4th pay cycle of each month, the 820 premium payment will run and will electronically transfer the appropriate per member per month capitation payment for each participant enrolled with each PAHP.

RESPONSE TO IRAI 8/9/2023: MDHHS ONLY MAKES PAYMENTS TO THE WAIVER AGENCIES AND NOT DIRECTLY TO THE PROVIDERS OF SERVICES.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☒ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

This is a concurrent §1915(b)/1915(c) waiver, and therefore, this section is not applicable.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Fourteen of the twenty waiver agencies are Area Agency on Aging (AAA) organizations. These entities are quasi-public organizations that generally report to a board with some county oversight. In addition to the AAAs, Northern Lakes Community Mental Health (otherwise known as Northern Health Care Management), and Macomb-Oakland Regional Center (or Easterseals MORC) are community mental health agencies; A & D Home Health Care, Inc. is a home health agency; Reliance Community Care Partners is a stand-alone care management agency; and The Information Center, Inc. and Milestone Senior Services, Inc. are information, referral and assistance agencies that function as a waiver agency.

All PAHPs directly employ qualified supports coordinators who furnish Supports Coordination. One waiver agency, Tri-County Office on Aging, prepares and provides home delivered meals. A&D Home Health Care, Inc. offers workers who furnish Community Living Supports. All waiver agencies may also make purchases from retail stores for items falling into the Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, and Goods and Services categories.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ○ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ◉ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The monthly capitated payment to the managed care entities is not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- ☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Residential service providers are limited to billing under a finite set of Healthcare Common Procedure Coding System (HCPCS) codes for their services. The codes do not include reimbursement for room and board. MDHHS did not include costs associated with room and board in the capitation rate development process. Waiver agencies negotiate rates with each residential services provider based upon the unique needs and circumstances of each participant in the residential setting on an individual basis. All MI Choice services are based upon the assessed medical and functional needs of the participant, and specifically exclude room and board except for the Respite service. Waiver agencies do not remit payments for room and board if such is received from the residential services provider. All payments to providers in residential settings are for approved MI Choice services only. MMIS will only approve encounter data claims for the approved HCPCS codes.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the

collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	19180.54	5212.59	24393.13	42914.08	3417.53	46331.61	21938.48
2	22441.44	6240.08	28681.52	52432.74	4095.65	56528.39	27846.87
3	23159.79	6427.28	29587.07	54530.05	4218.52	58748.57	29161.50
4	24005.79	6620.10	30625.89	56711.26	4345.08	61056.34	30430.45
5	24860.50	6818.71	31679.21	58979.71	4475.43	63455.14	31775.93

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	18734	18734
Year 2	20171	20171
Year 3	20543	20543
Year 4	20915	20915
Year 5	21287	21287

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Average Length of Stay (ALOS) was determined based on historic information regarding the number of days of participation in the MI Choice waiver program that each waiver agency reported. The rate of growth of the number of days was estimated based on the trend determined from past information. The estimated ALOS for the upcoming 5-year period was calculated by dividing the total estimated number of participation days per fiscal year by the projected unduplicated number of participants.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The Factor D values were estimated using historic information obtained from claim data submitted by waiver agencies for SFY 2021 and SFY 2022 (through March 31, 2023). Costs associated with waiver services that are to be continued as in the past, were calculated based on projecting the number of users per service, the average units per user, the average cost per unit and the number of units.

The numbers of users of each service were based on the projection using change in unduplicated participant count by waiver year. The average cost per unit in each year was estimated by reviewing recent cost trends observed in the waiver program. The average units per user for each year was based on change in average length of stay by waiver year.

RESPONSE TO CMS INITIAL ANALYSIS REPORT: The average cost per unit increase is generally consistent across all waiver services at approximately 3.6% per year. This inflationary adjustment is consistent across all waiver years, but there may be slight differences due to rounding. The larger aggregate increases for the noted services are due to those making up 90% of total expenditures for the waiver.

RESPONSE TO CMS INITIAL ANALYSIS REPORT: The annual growth rate for service cost was developed based on the actual increase in average cost per service across all waiver services from SFY 2021 (October 1, 2020 to September 30, 2021) to SFY 2022 (October 1, 2021 to September 30, 2022). The increase in Factor D cost for each waiver year also considers the changes in unduplicated participants.

IN RESPONSE TO RAI: VALUES HAVE INCREASED SLIGHTLY BASED ON UPDATED EXPERIENCE FOR THE ADDITION OF VEHICLE MODIFICATIONS AND SUPPORTS BROKERAGE SERVICES. COST NEUTRALITY OF THE WAIVER WAS NOT MATERIALLY IMPACTED.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' values were estimated using historic information obtained from past CMS 372 reports from SFY 2021 and SFY 2022 (through March 31, 2023) projected forward to SFY 2024-2028 based on State budget trends specific to State Plan services.

RESPONSE TO CMS INITIAL ANALYSIS REPORT: The 3% trend for Factor D' is based on state plan trends from budgetary development.

IN RESPONSE TO THE RAI: NO CHANGES DUE TO ADDITION OF SUPPORTS BROKERAGE AND VEHICLE MODIFICATIONS, BUT CHANGES OCCURRED DUE TO ADJUSTMENTS NEEDED FOR THE START OF WAIVER YEAR 1 CHANGING TO DECEMBER 1, 2023.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G values were estimated using historic information obtained from past CMS 372 reports from FY 2021 and SFY 2022 (through March 31, 2023) projected forward to SFY 2024-2028 based on State budget trends specific to nursing facility services.

RESPONSE TO CMS INITIAL ANALYSIS REPORT: The 4% trend for Factor G is based on nursing facility trends from budgetary development.

IN RESPONSE TO THE RAI: NO CHANGES DUE TO ADDITION OF SUPPORTS BROKERAGE AND VEHICLE MODIFICATIONS, BUT CHANGES OCCURRED DUE TO ADJUSTMENTS NEEDED FOR THE START OF WAIVER YEAR 1 CHANGING TO DECEMBER 1, 2023.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' values were estimated using historic information obtained from past CMS 372 reports from FY 2021 and SFY 2022 (through March 31, 2023) projected forward to SFY 2024-2028 based on State budget trends specific to State Plan services.

RESPONSE TO CMS INITIAL ANALYSIS REPORT: The 3% trend for Factor G' is based on state plan trends from budgetary development consistent with Factor D'.

IN RESPONSE TO THE RAI: NO CHANGES DUE TO ADDITION OF SUPPORTS BROKERAGE AND VEHICLE MODIFICATIONS, BUT CHANGES OCCURRED DUE TO ADJUSTMENTS NEEDED FOR THE START OF WAIVER YEAR 1 CHANGING TO DECEMBER 1, 2023.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Respite	
Supports Coordination	
Specialized Medical Equipment and Supplies	
Fiscal Intermediary	
Goods and Services	
Supports Brokerage	
Assistive Technology	
Chore Services	
Community Health Worker	
Community Living Supports	
Community Transportation	
Counseling	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Nursing Services	
Personal Emergency Response System	
Private Duty Nursing/Respiratory Care	
Residential Services	
Training	

Waiver Services	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**1646454.76**
Adult Day Health - Per 15 minutes	☒	15 Minutes	290	1426.49	3.98	**1646454.76**	
Respite Total:							**1672845.17**
Respite - Per 15 minutes	☒	15 Minutes	192	1293.18	5.52	**1370563.89**	
Respite - Per Diem	☒	Per Diem	133	13.56	167.61	**302281.28**	
Supports Coordination Total:							**68601194.42**
Supports Coordination - Per Month	☒	Month	17582	7.31	533.76	**68601194.42**	
Specialized Medical Equipment and Supplies Total:							**1865952.64**
Per Item	☒	Item	4100	7.99	56.96	**1865952.64**	
Fiscal Intermediary Total:							**2348207.15**
Per Month	☒	Month	2363	7.86	126.43	**2348207.15**	
Goods and Services Total:							**104106.76**
Per Item	☒	Item	163	12.01	53.18	**104106.76**	
Supports Brokerage Total:							**1280.00**
Supports Brokerage - Per	☒	15 minutes	2	160.00	4.00	**1280.00**	

GRAND TOTAL:	**359328293.88**
Total: Services included in capitation:	359328293.88
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**18734**
Factor D (Divide total by number of participants):	**19180.54**
Services included in capitation:	19180.54
Services not included in capitation:	
Average Length of Stay on the Waiver:	216

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
15 minutes							
Assistive Technology Total:							**85195.83**
Per Item	☒	Item	107	0.91	874.97	**85195.83**	
Chore Services Total:							**958811.62**
Per 15 minutes	☒	15 Minutes	1212	84.07	9.41	**958811.62**	
Community Health Worker Total:							**1280.00**
Per 15 minutes	☒	15 Minutes	2	160.00	4.00	**1280.00**	
Community Living Supports Total:							**178655903.53**
Per 15 minutes	☒	15 Minutes	11764	3007.26	5.05	**178655903.53**	
Community Transportation Total:							**4331950.60**
Per Mile	☒	Trip/Mile	4276	904.54	1.12	**4331950.60**	
Counseling Total:							**83101.65**
Per visit	☒	Visit	142	14.73	39.73	**83101.65**	
Environmental Accessibility Adaptations Total:							**854257.19**
Per service	☒	Item	275	0.94	3304.67	**854257.20**	
Home Delivered Meals Total:							**6061656.75**
Per Meal	☒	Meal	4854	194.82	6.41	**6061656.75**	
Nursing Services Total:							**2475507.04**
Per 15 minutes	☒	15 Minutes	1409	148.64	11.82	**2475507.04**	
Personal Emergency Response System Total:							**1366008.54**
Per month	☒	Month/Install	5916	6.87	33.61	**1366008.54**	
Private Duty Nursing/Respiratory Care Total:							**11580227.40**

GRAND TOTAL:	**359328293.88**
Total: Services included in capitation:	359328293.88
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**18734**
Factor D (Divide total by number of participants):	**19180.54**
Services included in capitation:	19180.54
Services not included in capitation:	
Average Length of Stay on the Waiver:	216

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per 15 minutes	☒	15 Minutes	120	8055.25	11.98	11580227.40	
Residential Services Total:							76571154.85
Per 15 minutes	☒	15 Minutes	5042	3007.26	5.05	76571154.85	
Training Total:							59164.80
Per 15 minutes	☒	15 Minutes	395	4.23	35.41	59164.80	
Vehicle Modifications Total:							4033.16
Vehicle Modifications - per service	☒	service	4	1.00	1008.29	4033.16	

GRAND TOTAL:		359328293.88
Total: Services included in capitation:		359328293.88
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		18734
Factor D (Divide total by number of participants):		19180.54
Services included in capitation:		19180.54
Services not included in capitation:		
Average Length of Stay on the Waiver:	216	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							2071370.87
Adult Day Health - Per 15 minutes	☒	15 Minutes	312	1611.41	4.12	2071370.87	
Respite Total:							2110082.95
Respite - Per 15 minutes	☒	15 Minutes	207	1460.81	5.72	1729657.47	

GRAND TOTAL:		452666195.75
Total: Services included in capitation:		452666195.75
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		20171
Factor D (Divide total by number of participants):		22441.44
Services included in capitation:		22441.44
Services not included in capitation:		
Average Length of Stay on the Waiver:	244	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - Per Diem	☒	Per Diem	143	15.32	173.65	380425.47	
Supports Coordination Total:							86472643.18
Supports Coordination - Per Month	☒	Month	18931	8.26	553.00	86472643.18	
Specialized Medical Equipment and Supplies Total:							2352045.36
Per Item	☒	Item	4414	9.03	59.01	2352045.36	
Fiscal Intermediary Total:							2959158.41
Per Month	☒	Month	2544	8.88	130.99	2959158.41	
Goods and Services Total:							131596.43
Per Item	☒	Item	176	13.57	55.10	131596.43	
Supports Brokerage Total:							1496.53
Supports Brokerage - Per 15 minutes	☒	15 minutes	2	180.74	4.14	1496.53	
Assistive Technology Total:							107376.11
Per Item	☒	Item	115	1.03	906.51	107376.11	
Chore Services Total:							1208374.54
Per 15 minutes	☒	15 Minutes	1305	94.97	9.75	1208374.54	
Community Health Worker Total:							1496.53
Per 15 minutes	☒	15 Minutes	2	180.74	4.14	1496.53	
Community Living Supports Total:							225034044.35
Per 15 minutes	☒	15 Minutes	12666	3397.09	5.23	225034044.35	
Community Transportation Total:							5457065.95
Per Mile	☒	Trip/Mile	4604	1021.80	1.16	5457065.95	
Counseling Total:							104790.07
Per visit	☒					104790.07	

GRAND TOTAL:	**452666195.75**
Total: Services included in capitation:	452666195.75
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**20171**
Factor D (Divide total by number of participants):	**22441.44**
Services included in capitation:	22441.44
Services not included in capitation:	
Average Length of Stay on the Waiver:	244

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Visit	153	16.64	41.16		
Environmental Accessibility Adaptations Total:							**1074248.35**
Per service	☒	Item	296	1.06	3423.79	**1074248.35**	
Home Delivered Meals Total:							**7636569.84**
Per Meal	☒	Meal/Prep	5226	220.07	6.64	**7636569.84**	
Nursing Services Total:							**3120313.51**
Per 15 minutes	☒	15 Minutes	1517	167.91	12.25	**3120313.51**	
Personal Emergency Response System Total:							**1721194.38**
Per month	☒	Month/Install	6370	7.76	34.82	**1721194.38**	
Private Duty Nursing/Respiratory Care Total:							**14567218.51**
Per 15 minutes	☒	15 Minutes	129	9099.45	12.41	**14567218.51**	
Residential Services Total:							**96455852.42**
Per 15 minutes	☒	15 Minutes	5429	3397.09	5.23	**96455852.42**	
Training Total:							**74535.74**
Per 15 minutes	☒	15 Minutes	425	4.78	36.69	**74535.74**	
Vehicle Modifications Total:							**4721.73**
Vehicle Modifications - per service	☒	service	4	1.13	1044.63	**4721.73**	

GRAND TOTAL:	**452666195.75**
Total: Services included in capitation:	452666195.75
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**20171**
Factor D (Divide total by number of participants):	**22441.44**
Services included in capitation:	22441.44
Services not included in capitation:	
Average Length of Stay on the Waiver:	244

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that*

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**2179107.31**
Adult Day Health - Per 15 minutes	☒	15 Minutes	318	1604.81	4.27	**2179107.31**	
Respite Total:							**2221146.71**
Respite - Per 15 minutes	☒	Per 15 Minutes	211	1454.82	5.93	**1820314.43**	
Respite - Per Diem	☒	Per Diem	146	15.26	179.91	**400832.28**	
Supports Coordination Total:							**90909323.99**
Supports Coordination - Per Month	☒	Month	19280	8.23	572.93	**90909323.99**	
Specialized Medical Equipment and Supplies Total:							**2470670.46**
Per Item	☒	Item	4495	8.99	61.14	**2470670.46**	
Fiscal Intermediary Total:							**3108361.55**
Per Month	☒	Month	2591	8.84	135.71	**3108361.55**	
Goods and Services Total:							**138060.18**
Per Item	☒	Item	179	13.51	57.09	**138060.18**	
Supports Brokerage Total:							**1544.40**
Supports Brokerage - Per 15 minutes	☒	15 minutes	2	180.00	4.29	**1544.40**	
Assistive Technology Total:							**113180.58**
Per Item	☒	Item	117	1.03	939.18	**113180.58**	
Chore Services Total:							**1269537.88**
Per 15 minutes	☒	15 Minutes	1329	94.58	10.10	**1269537.88**	
Community Health Worker Total:							**1544.40**
Per 15 minutes	☒					**1544.40**	

	GRAND TOTAL:	***475771518.52***
	Total: Services included in capitation:	*475771518.52*
	Total: Services not included in capitation:	
	Total Estimated Unduplicated Participants:	***20543***
	Factor D (Divide total by number of participants):	***23159.79***
	Services included in capitation:	*23159.79*
	Services not included in capitation:	
	Average Length of Stay on the Waiver:	*243*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 Minutes	2	180.00	4.29		
Community Living Supports Total:							**236544480.06**
Per 15 minutes	☒	15 Minutes	12900	3383.17	5.42	**236544480.06**	
Community Transportation Total:							**5725887.95**
Per Mile	☒	Trip/Mile	4689	1017.61	1.20	**5725887.95**	
Counseling Total:							**110220.99**
Per visit	☒	Visit	156	16.57	42.64	**110220.99**	
Environmental Accessibility Adaptations Total:							**1131769.63**
Per service	☒	Item	301	1.06	3547.20	**1131769.63**	
Home Delivered Meals Total:							**8024988.45**
Per Meal	☒	Meal/Prep	5322	219.17	6.88	**8024988.45**	
Nursing Services Total:							**3278523.68**
Per 15 minutes	☒	15 Minutes	1545	167.22	12.69	**3278523.68**	
Personal Emergency Response System Total:							**1809213.92**
Per month	☒	Month/Install	6487	7.73	36.08	**1809213.92**	
Private Duty Nursing/Respiratory Care Total:							**15266658.47**
Per 15 minutes	☒	15 Minutes	131	9062.16	12.86	**15266658.47**	
Residential Services Total:							**101384064.36**
Per 15 minutes	☒	15 Minutes	5529	3383.17	5.42	**101384064.36**	
Training Total:							**78341.65**
Per 15 minutes	☒	15 Minutes	433	4.76	38.01	**78341.65**	
Vehicle Modifications Total:							**4891.91**

GRAND TOTAL:	**475771518.52**
Total: Services included in capitation:	475771518.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**20543**
Factor D (Divide total by number of participants):	**23159.79**
Services included in capitation:	23159.79
Services not included in capitation:	
Average Length of Stay on the Waiver:	243

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications - per service	☒	service	4	1.13	1082.28	4891.91	

GRAND TOTAL:		**475771518.52**
Total: Services included in capitation:		475771518.52
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**20543**
Factor D (Divide total by number of participants):		**23159.79**
Services included in capitation:		23159.79
Services not included in capitation:		
Average Length of Stay on the Waiver:	243	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**2298216.30**
Adult Day Health - Per 15 minutes	☒	15 Minutes	324	1604.81	4.42	**2298216.30**	
Respite Total:							**2344310.28**
Respite - Per 15 minutes	☒	Per 15 Minutes	215	1454.82	6.14	**1920507.88**	
Respite - Per Diem	☒	Per Diem	149	15.26	186.39	**423802.40**	
Supports Coordination Total:							**95890872.38**
Supports Coordination - Per Month	☒	Month	19629	8.23	593.58	**95890872.38**	
Specialized Medical Equipment and Supplies Total:							**2605696.12**
Per Item	☒	Item	4576	8.99	63.34	**2605696.12**	
Fiscal Intermediary Total:							**3278780.75**

GRAND TOTAL:		**502081119.67**
Total: Services included in capitation:		502081119.67
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**20915**
Factor D (Divide total by number of participants):		**24005.79**
Services included in capitation:		24005.79
Services not included in capitation:		
Average Length of Stay on the Waiver:	243	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Month	☒	Month	2638	8.84	140.60	3278780.75	
Goods and Services Total:							145439.20
Per Item	☒	Item	182	13.51	59.15	145439.20	
Supports Brokerage Total:							1598.40
Supports Brokerage - Per 15 minutes	☒	15 minutes	2	180.00	4.44	1598.40	
Assistive Technology Total:							119264.29
Per Item	☒	Item	119	1.03	973.03	119264.29	
Chore Services Total:							1338532.10
Per 15 minutes	☒	15 Minutes	1353	94.58	10.46	1338532.10	
Community Health Worker Total:							1598.40
Per 15 minutes	☒	15 Minutes	2	180.00	4.44	1598.40	
Community Living Supports Total:							249722197.86
Per 15 minutes	☒	15 Minutes	13134	3383.17	5.62	249722197.86	
Community Transportation Total:							6024006.97
Per Mile	☒	Trip/Mile	4774	1017.61	1.24	6024006.97	
Counseling Total:							116397.95
Per visit	☒	Visit	159	16.57	44.18	116397.95	
Environmental Accessibility Adaptations Total:							1192042.46
Per service	☒	Item	306	1.06	3675.06	1192042.46	
Home Delivered Meals Total:							8466611.62
Per Meal	☒	Meal/Prep	5418	219.17	7.13	8466611.62	
Nursing Services Total:							3458937.34
Per 15 minutes	☒	15 Minutes	1573	167.22	13.15	3458937.34	

GRAND TOTAL:	**502081119.67**
Total: Services included in capitation:	502081119.67
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**20915**
Factor D (Divide total by number of participants):	**24005.79**
Services included in capitation:	24005.79
Services not included in capitation:	
Average Length of Stay on the Waiver:	243

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Total:							**1908208.63**
Per month	☒	Month/Install	6604	7.73	37.38	**1908208.63**	
Private Duty Nursing/Respiratory Care Total:							**16054160.17**
Per 15 minutes	☒	15 Minutes	133	9062.16	13.32	**16054160.17**	
Residential Services Total:							**107026515.29**
Per 15 minutes	☒	15 Minutes	5629	3383.17	5.62	**107026515.29**	
Training Total:							**82664.92**
Per 15 minutes	☒	15 Minutes	441	4.76	39.38	**82664.92**	
Vehicle Modifications Total:							**5068.23**
Vehicle Modifications - per service	☒	service	4	1.13	1121.29	**5068.23**	

GRAND TOTAL:	**502081119.67**
Total: Services included in capitation:	502081119.67
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**20915**
Factor D (Divide total by number of participants):	**24005.79**
Services included in capitation:	24005.79
Services not included in capitation:	
Average Length of Stay on the Waiver:	243

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

GRAND TOTAL:	**529205365.82**
Total: Services included in capitation:	529205365.82
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**21287**
Factor D (Divide total by number of participants):	**24860.50**
Services included in capitation:	24860.50
Services not included in capitation:	
Average Length of Stay on the Waiver:	243

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**2425509.83**
Adult Day Health - Per 15 minutes	☒	15 Minutes	330	1604.81	4.58	**2425509.83**	
Respite Total:							**2474254.00**
Respite - Per 15 minutes	☒	Per 15 Minutes	219	1454.82	6.36	**2026331.49**	
Respite - Per Diem	☒	Per Diem	152	15.26	193.11	**447922.51**	
Supports Coordination Total:							**101114359.72**
Supports Coordination - Per Month	☒	Month	19978	8.23	614.98	**101114359.72**	
Specialized Medical Equipment and Supplies Total:							**2747275.14**
Per Item	☒	Item	4657	8.99	65.62	**2747275.14**	
Fiscal Intermediary Total:							**3457535.72**
Per Month	☒	Month	2685	8.84	145.67	**3457535.72**	
Goods and Services Total:							**153160.17**
Per Item	☒	Item	185	13.51	61.28	**153160.17**	
Supports Brokerage Total:							**1656.00**
Supports Brokerage - Per 15 minutes	☒	15 minutes	2	180.00	4.60	**1656.00**	
Assistive Technology Total:							**125639.50**
Per Item	☒	Item	121	1.03	1008.10	**125639.50**	
Chore Services Total:							**1411765.39**
Per 15 minutes	☒	15 Minutes	1377	94.58	10.84	**1411765.39**	
Community Health Worker Total:							**1656.00**
Per 15 minutes	☒	15 Minutes	2	180.00	4.60	**1656.00**	
Community Living Supports Total:							**263216580.38**
Per 15 minutes	☒	15 Minutes				**263216580.38**	

GRAND TOTAL:	**529205365.82**
Total: Services included in capitation:	529205365.82
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**21287**
Factor D (Divide total by number of participants):	**24860.50**
Services included in capitation:	24860.50
Services not included in capitation:	
Average Length of Stay on the Waiver:	243

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			13368	3383.17	5.82		
Community Transportation Total:							**6329045.75**
Per Mile	☒	Trip/Mile	4859	1017.61	1.28	**6329045.75**	
Counseling Total:							**122862.24**
Per visit	☒	Visit	162	16.57	45.77	**122862.24**	
Environmental Accessibility Adaptations Total:							**1255190.34**
Per service	☒	Item	311	1.06	3807.53	**1255190.34**	
Home Delivered Meals Total:							**8930839.98**
Per Meal	☒	Meal/Prep	5514	219.17	7.39	**8930839.98**	
Nursing Services Total:							**3646335.78**
Per 15 minutes	☒	15 Minutes	1601	167.22	13.62	**3646335.78**	
Personal Emergency Response System Total:							**2012152.47**
Per month	☒	Month/Install	6721	7.73	38.73	**2012152.47**	
Private Duty Nursing/Respiratory Care Total:							**16882804.08**
Per 15 minutes	☒	15 Minutes	135	9062.16	13.80	**16882804.08**	
Residential Services Total:							**112804293.01**
Per 15 minutes	☒	15 Minutes	5729	3383.17	5.82	**112804293.01**	
Training Total:							**87199.39**
Per 15 minutes	☒	15 Minutes	449	4.76	40.80	**87199.39**	
Vehicle Modifications Total:							**5250.93**
Vehicle Modifications - per service	☒	service	4	1.13	1161.71	**5250.93**	

GRAND TOTAL:		**529205365.82**
Total: Services included in capitation:		529205365.82
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**21287**
Factor D (Divide total by number of participants):		**24860.50**
Services included in capitation:		24860.50
Services not included in capitation:		
Average Length of Stay on the Waiver:	243	