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

Medicaid and CHIP Operations Group

June 26, 2026

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

RE: 1915(c) MI.0167.R07.01 Michigan's Habilitation Supports Waiver Program

Dear Deputy Director Groen:

The Centers for Medicare & Medicaid Services (CMS) approves your request to amend Michigan's Habilitation Supports Waiver Program, which serves individuals with intellectual/developmental disabilities who, if not for the availability and provisions of HSW services would otherwise require the level of care services provided in an ICF/IID. The CMS Control Number for the amendment is MI.0167.R07.01. Please use this number in future correspondence relevant to this waiver action.

The purpose of this amendment is to update the waiver to reflect federal requirements, operational changes, and financial assumptions associated with the continued administration of Home and Community-Based Services (HCBS). With the amendment, the state revised language to reflect the Michigan Department of Health and Human Services (MDHHS) organizational restructuring, strengthen oversight and compliance with the federal HCBS Settings Rule, and establish new HCBS training requirements for direct support workers. The amendment also incorporates additional safeguards related to Conflict-Free Access and Planning, clarifies participant-directed service provisions, and updates projected participation goals for individuals. Lastly, the amendment updates Appendix J cost neutrality calculations and assumptions using State Fiscal Year 2024 enrollment, encounter, and expenditure data. This amendment does not reduce waiver eligibility, eliminate major waiver services, or reduce participant capacity. Rather, it serves primarily as a compliance, oversight, training, and financial update designed to align the waiver with current federal requirements and anticipated program operations. The effective date of the amendment is July 1, 2026.

This approval is subject to your agreement to serve no more individuals than the total number of unduplicated participants indicated in Appendix J.2 of the waiver. If the state wishes to serve more individuals or make any other alterations to this waiver, an amendment must be submitted for approval.

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

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

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

Sincerely,

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

cc: Christine Davidson, CMCS, DPO
Lynell Sanderson, CMCS, DLTSS
Matthew S. Weaver, CMCS, DLTSS
Curtis Cunninghan, CMCS, DLTSS
Mark Halter, CMCS, FMG

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 section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
Habilitation Supports Waiver

C. Waiver Number:MI.0167
Original Base Waiver Number: MI.0167.

D. Amendment Number:MI.0167.R07.01

E. Proposed Effective Date: (mm/dd/yy)
07/01/26

Approved Effective Date: 07/01/26
Approved Effective Date of Waiver being Amended: 10/01/24

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

THE PURPOSE FOR THE AMENDMENT INCLUDES THE FOLLOWING:

WAIVER APPLICATION UPDATED TO REFLECT RESTRUCTURE OF MDHHS FROM BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICE ADMINISTRATION TO HEALTH SERVICES. THIS UPDATE IS REFLECTED THROUGHOUT THE WAIVER AMENDMENT. THIS UPDATE WAS EFFECTIVE 4/1/2025 AND IS CONSIDERED A TECHNICAL CORRECTION. THE ACRONYM FOR BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION (BPHASA) WAS REMOVED AND MDHHS LANGUAGE REMAINED. RELEVANT SECTIONS OF THE WAIVER WHICH WERE UPDATED INCLUDE: 2.BRIEF WAIVER DESCRIPTION, A-1, A-2.a, A-6, A-7.b.i, B-3.e, D-1.b, D-2.b, G-1.b, G-1.d, G-1.e, I-1.a.i.b.ii, I-1.b.i.

ADDING PERFORMANCE MEASURE TO WAIVER ADMINISTRATION AND OPERATION FOR OVERSIGHT OF HCBS SETTINGS PROTECTIONS.

ADDING HCBS TRAINING REQUIREMENTS FOR INDIVIDUALS WHO PROVIDE CASE MANAGEMENT SERVICES, COMMUNITY LIVING SUPPORTS, OUT-OF-HOME NONVOCATIONAL HABILITATION, SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT, SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT.

ADDING CLARIFYING INFORMATION FOR PARTICIPATION DIRECTION OF SERVICES.

ADDING UPDATED GOALS FOR PARTICIPANT DIRECTION REFLECTING THE PROJECTED NUMBER PARTICIPANTS FOR EACH WAIVER YEAR FOR (1) EMPLOYER AUTHORITY ONLY AND (2) BUDGET AUTHORITY ONLY OR BUDGET AUTHORITY IN COMBINATION WITH EMPLOYER AUTHORITY. THE PARTICIPANT PROJECTION IS BASED UPON SFY 2024 BASE DATA INCREASED BY 7.5% PER YEAR CORRESPONDING TO THE ANNUALIZED GROWTH RATE BETWEEN SFY 2022 AND SFY 2024. INDIVIDUALS WERE CONSIDERED PARTICIPANT DIRECTED FOR SFY 2024 IF THEY HAD A U7 MODIFIER ON AN APPROPRIATE HCPCS OR HAD A T2025 ENCOUNTER.

ADDING UPDATED VALUES AND NARRATIVES CORESPONDING TO APPENDIX J, COST NEUTRALITY DEMONSTRATION. THIS AMENDMENT IS INTENDED TO UPDATE THE HSW RENEWAL APPLICATION TO REFLECT THE POLICY AND PROGRAM CHANGES BELOW AND TO ALIGN THE PROJECTED COSTS PER UNIT AND UTILIZATION ASSUMPTIONS WITH THE ANTICIPATED SFY 2026 HSW CAPITATION RATES. ASSUMPTIONS AND METHODOLOGY INCLUDE THE FOLLOWING:
•UPDATED BASE DATA TO SFY 2024 ENROLLMENT, ENCOUNTER, AND FINANCIAL REPORTING DATA - OCTOBER 1, 2023 THROUGH SEPTEMBER 30, 2024
•INCREASED COST PER UNIT VALUES FOR PRIVATE DUTY NURSING SERVICES BY 25% PER LEGISLATIVE MANDATE
•ADJUSTED COST PER UNIT VALUES TO REFLECT THE COMBINED IMPACT OF MICHIGAN'S DIRECT CARE WORKER (DCW) ADJUSTMENT, MINIMUM WAGE LAWS, AND EARNED SICK TIME ACT (ESTA)
•REFLECTED THE IMPACT OF THE WASKUL LAWSUIT SETTLEMENT ON SELF-DETERMINATION COMMUNITY LIVING SUPPORTS (SD CLS) AND OVERNIGHT HEALTH AND SAFETY SUPPORTS (SD OHSS) SERVICES
•INCREASED ANNUAL COST PER UNIT TREND FOR FACTOR D FROM 4.0% TO 4.6% FOR WY 1 AND WY 2
•INCREASED MANAGED CARE ADMINISTRATION AND RISK MARGIN ASSUMPTIONS FROM 5.0% TO A COMBINED 8.1%
•ADDED A PER DIEM SERVICE OPTION FOR COMMUNITY LIVING SUPPORTS (CLS) - BUDGET NEUTRAL IMPACT
•ADDED A PER DIEM SERVICE OPTION FOR OVERNIGHT HEALTH AND SAFETY SUPPORTS (OHSS) - BUDGET NEUTRAL IMPACT
•UPDATED ANNUAL COST PER UNIT TREND FACTORS FOR FACTOR G
•REFLECTED THE 10/1/2025 INCREASE IN HOME HELP RATES IN FACTOR D` DEVELOPMENT

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	2. BRIEF WAIVER DESCRIPTION
☑ Appendix A - Waiver Administration and Operation	A.1, A.2.a, A.6, A.7.a.ii, A-7.b.i
☑ Appendix B - Participant Access and Eligibility	B-3.e
☑ Appendix C - Participant Services	C-1, C-5
☑ Appendix D - Participant Centered Service Planning and Delivery	D-1. a, D-1. b, D-1. d. i(h)(i), D-1.d.ii ,D-2.b
☑ Appendix E - Participant Direction of Services	E.1.m, E.1.n, E.2.b.ii, E.2.b.iii
☐ Appendix F - Participant Rights	
☑ Appendix G - Participant Safeguards	G-1.b, G-1.d, G-1.e
☐ Appendix H	
☑ Appendix I - Financial Accountability	I-1.a.i.b.ii, I-1.b.i
☑ Appendix J - Cost-Neutrality Demonstration	J-1, J-2.b, J-2.c, J-2.d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☑ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☑ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☑ **Other**

Specify:

WAIVER APPLICATION UPDATED TO REFLECT RESTRUCTURE OF MDHHS FROM BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICE ADMINISTRATION TO HEALTH SERVICES. THIS UPDATE IS REFLECTED THROUGHOUT THE WAIVER AMENDMENT. THIS UPDATE WAS EFFECTIVE 4/1/2025 AND IS CONSIDERED A TECHNICAL CORRECTION. THE ACRONYM FOR BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION (BPHASA) WAS REMOVED AND MDHHS LANGUAGE REMAINED. RELEVANT SECTIONS OF THE WAIVER WHICH WERE UPDATED INCLUDE: 2.BRIEF WAIVER DESCRIPTION, A-1, A-2.a, A-6, A-7.b.i, B-3.e, D-1.b, D-2.b, G-1.b, G-1.d, G-1.e, I-1.a.i.b.ii, I-1.b.i.

A.6 & A.7.a.ii ADDING PERFORMANCE MEASURE TO WAIVER ADMINISTRATION AND OPERATION FOR OVERSIGHT OF HCBS SETTINGS PROTECTIONS.

C-1 IDENTIFICATION OF REMOTE DELIVERY OF SERVICE OPTION RELATED TO NEW CMS APPLICATION FOR IDENTIFIED SERVICES.

C-1 ADDING HCBS TRAINING REQUIREMENTS INDIVIDUALS WHO PROVIDE CASE MANAGEMENT SERVICES, COMMUNITY LIVING SUPPORTS, OUT-OF-HOME NONVOCATIONAL HABILITATION, SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT, SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT.

C-5 UPDATING HCBS SETTINGS LANGUAGE AND COMPLETING HCBS ASSURANCES AS OUTLINED IN NEW WAIVER APPLICATION.

D-1.a ADDING HCBS TRAINING REQUIREMENTS FOR THOSE RESPONSIBLE FOR SERVICE PLAN DEVELOPMENT.

D-1.b COMPLETING ATTESTATIONS FOR SAFEGUARDS FOR CONFLICT OF INTEREST IN SERVICE PLAN DEVELOPMENT RELATED TO NEW CMS APPLICATION

D-1.d.i(h)(i) ADDING LANGUAGE TO ADDRESS NEW CMS APPLICATION FOR SERVICE PLAN DEVELOPMENT PROCESS.

D-1.d.ii COMPLETING ASSURANCES FOR HCBS SETTINGS REQUIRMENTS FOR THE SERVICE PLAN RELATED TO NEW CMS APPLICATION.

D-2.b COMPLETING ASSURANCES FOR MONITORING SAFEGUARDS FOR CONFLICT OF INTEREST IN SERVICE PLAN IMPLEMENTATION, PARTICIPANT HEALTH AND WELFARE, AND ADHERENCE TO THE HCBS SETTINGS REQUIREMENTS RELATED TO NEW CMS APPLICATION.

E.1.m, E-1.n, E.2.b.ii, E.2.b.iii ADDING CLARIFYING INFORMATION FOR PARTICIPATION DIRECTION OF SERVICES AND UPDATE OF GOALS FOR PARTICIPANT DIRECTION TABLE.

J-1, J-2.b, J-2.c, J-2.d ADDING UPDATED VALUES AND NARRATIVES CORESPONDING TO APPENDIX J. THIS AMENDMENT IS INTENDED TO UPDATE THE HSW RENEWAL APPLICATION TO REFLECT THE POLICY AND PROGRAM CHANGES BELOW AND TO ALIGN THE PROJECTED COSTS PER UNIT AND UTILIZATION ASSUMPTIONS WITH THE ANTICIPATED SFY 2026 HSW CAPITATION RATES. ASSUMPTIONS AND METHODOLOGY INCLUDE THE FOLLOWING:
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•UPDATED ANNUAL COST PER UNIT TREND FACTORS FOR FACTOR G
•REFLECTED THE 10/1/2025 INCREASE IN HOME HELP RATES IN FACTOR D` DEVELOPMENT

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 section 1915(c) of the Social Security Act (the Act).

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

Habilitation Supports Waiver

C. Type of Request: amendment

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.0167
Waiver Number:MI.0167.R07.01
Draft ID: MI.014.07.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/24
Approved Effective Date of Waiver being Amended: 10/01/24

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

☐ **A program operated under section 1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

THE MANAGED CARE AUTHORITY FOR THE 1915(C) WAIVER IS DERIVED FROM THE MICHIGAN 1115 BEHAVIORAL HEALTH DEMONSTRATION

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

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

2. Brief Waiver Description

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

Originally approved by HEALTH CARE FINANCING ADMINSTRATION (HCFA) effective 10/1/1987, the Habilitation Supports Waiver (HSW) was Michigan's primary vehicle for reducing use of its Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) by allowing a strategic set of long-term services and supports to be delivered in community settings. Since that approval, unduplicated ICF/IID users have dropped from just under 4000 to zero. The HSW now functions as the state's primary vehicle for supporting people in the community by enrolling people who were placed out of the ICF/IID and deflecting those who might otherwise require ICF/IID level of services. The purpose of the Habilitation Supports Waiver (HSW) is to provide community-based services to people with intellectual/developmental disabilities who, if not for the availability and provisions of HSW services would otherwise require the level of care services provided in an ICF/IID. The goal of the HSW is to enable people with intellectual/developmental disabilities who have significant needs and who meet the HSW eligibility requirements to live and fully participate in their communities. The objective is to provide regular Medicaid State Plan and Additional Services through the Michigan 1115 Behavioral Health Demonstration, 1915(i) State Plan Amendment (SPA) and waiver services through the HSW that address the beneficiary's identified needs.

The HSW eligibility requirements include: 1) the beneficiary is a person of any age with an intellectual/developmental disability, 2) the beneficiary is living in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving HSW services, 3) the beneficiary has current Medicaid eligibility, and 4) the beneficiary would otherwise require the level of care services provided in an ICF/IID if not for the availability and provision of HSW services in the community. The HSW beneficiary must require and receive at least one HSW habilitative service per month.

Waiver services include: Community Living Supports (CLS), Enhanced Medical Equipment & Supplies, Enhanced Pharmacy, Environmental Modifications, Family Training, Financial Management Services, Goods & Services, Non-Family Training, Out-of-Home Nonvocational Habilitation, Overnight Health and Safety Support, Personal Emergency Response System, Private Duty Nursing, Respite Care, VEHICLE MODIFICATION, Supported Employment-INDIVIDUAL SUPPORTED EMPLOYMENT AND SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT.

Oversight of the HSW is provided by Michigan Department of Health and Human Services (MDHHS), which is the Single State Medicaid Agency. Since the last renewal in 2019, MDHHS went through a reorganization. The Medicaid Services Administration (MSA) who had responsibility for operations and payments, respectively, went through a reorganization and BECAME the Behavioral and Physical Health and Aging Services Administration (BPHASA). Additionally, a new bureau was created with a focus on children's specialty behavioral health services at this time.

IN FY 25 BPHASA WENT THROUGH A RESTRUCTURING EFFECTIVE 4/1/2025 AND IS NOW HEALTH SERVICES. HEALTH SERVICES IS THE ADMINISTRATION THAT OVERSEES THE OPERATIONS OF THE HSW. The administration, operation, and oversight of the 1915(c) waivers is now shared across two bureaus: the Bureau of Specialty Behavioral Health Services (BSBHS) which is under HEALTH SERVICES and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). HEALTH SERVICES and BCCHPS continue to operate under MDHHS. Throughout the waiver application, MDHHS will be used to collectively capture HEALTH SERVICES and BCCHPS involvement with the Habilitation Support Waiver. The HSW operates concurrently with the Michigan 1115 Behavioral Health Demonstration as a managed care program. The HSW is administered and monitored by MDHHS. The HSW is managed regionally by the prepaid inpatient health plans (PIHP) under contract with MDHHS. services are provided locally by the community mental health services programs (CMHSPS) or its contracted Providers. HSW beneficiaries may receive any medically necessary services provided under Medicaid State Plan, additional Michigan 1115 Behavioral Health Demonstration, and 1915(i)State Plan Amendment (SPA) as well as all HSW services. Beneficiaries enrolled in the HSW may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the

individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

Prior to decisions being made regarding changes for the Habilitation Supports Waiver amendment, MDHHS solicited feedback through a variety of avenues between May and December 2025. MDHHS held waiver feedback meetings with internal and external community partners. The meetings were widely distributed to invite multiple community/public groups, including MDHHS staff, PIHP/CMHSP staff, community partners, advocacy groups, and families. The goal of the feedback meetings was to discuss current waiver services, processes, and operations, and gather feedback on suggested changes to each of these areas. Feedback was also received through scheduled meetings with internal MDHHS staff and external partners, as well as via email on an ongoing basis. The consolidated feedback was discussed in depth with MDHHS waiver staff to begin drafting potential changes for the waiver amendment. As submitted to CMS, a draft of the full waiver amendment application was provided by MDHHS during the public input period. MDHHS sent a Tribal notice on 01/29/2026 to provide an opportunity for Tribal members to review the waiver applications and submit comments. The period of Tribal comment ended 03/16/2026. The general public notice/comment period was 02/12/2026-03/16/2026. Non-electronic public notice: Public notice was released via several of the major newspapers statewide on 10/17/2025, 10/18/2025 and 10/19/2025. The newspaper notices included the website where the applications were posted as well as the email address and mailing address where comments and requests could be submitted. The website where the waiver applications were posted for review and comment is: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/medwaivers/habilitation-supports-waiver. Responses to specific comments are addressed below:

COMMENT: One commenter requested clarification and expressed concern regarding HCBS training requirements for identified staff. RESPONSE: Thank you for your comment. This is corrective action in response to the CMS onsite review. CMS has required providers of community-based services, specifically CLS, Out-of Home Nonvocational Habilitation and Support Employment providers, to receive HCBS training upon hire and annually thereafter.

COMMENT: One commenter expressed concerns with remote delivery of services and monitoring. RESPONSE: Thank you for your comment and recommendation. Please reference MMP 23-10, Telemedicine Policy Post-COVID-19 Public Health Emergency, IX. Specific Program/Service Site Considerations, B. Behavioral Health for guidance.

COMMENT: One commenter expressed concerns with remote delivery of service options and monitoring the quality and effectiveness of services delivered. This commenter also requested clarification on the meaning of "hands-on" care. RESPONSE: Thank you for your comment and recommendation. Please reference MMP 23-10, Telemedicine Policy Post-COVID-19 Public Health Emergency, IX. Specific Program/Service Site Considerations, B. Behavioral Health for guidance. The intent of "hands-on care" is for the service to be delivered in person.

COMMENT: There were 19 comments provided regarding concerns around CFA&P language within the amendment. Four of these commenters also had questions to address regarding this language. RESPONSE: Thank you for your comment. The language you are referencing in your comment is language that was approved for our waiver renewal and is not new language. This language was guided, reviewed, and approved by the Centers for Medicare and Medicaid. CFA&P language is a required element of the HCBS Rule and MI must comply with all elements of this rule to participate in HCBS Medicaid-funded services as found in 42 CFR 441.301(c)(1)(vi): "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process."

COMMENT: One commenter expressed concern of the addition of performance measures around HCBS and Conflict Free being excessive to the system. RESPONSE: Thank you for your comment. MDHHS is required by CMS to have performance measures in place to ensure compliance with federal requirements. CFA&P is a requirement under the Home and Community Based Access Rule.

COMMENT: One commenter expressed concern regarding a conflict of interest in SD arrangements. RESPONSE: Thank you for your comment. A conflict of interest should not occur in Self-Directed arrangements.

COMMENT: One commenter requested information on Only Willing and Qualified Provider designation. RESPONSE: Thank you for your comment. Please reference CFA&P webpage for further information and email any questions related to mdhhs-conflictfreeaccess@michigan.gov.

COMMENT: One commenter expressed concern about the financial impacts to the updates of Appendix J with a recommendation for additional guidance to be issued to the CMHSPs and PIHPs. RESPONSE: Thank you for your comment and recommendation. MDHHS evaluates potential budget implications for the HSW on an ongoing basis.

COMMENT: One commenter requested technical guidance for coordination of service through the CCBHC and the HSW case management provider. RESPONSE: Thank you for your comment. The requirements for our case management coordination did not change with this HSW Amendment and is not open for public comment. Please reference the CCBHC Handbook for guidance.

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

Address: 400 South Pine St

Address 2: P.O. Box 30479

City: Lansing

State: **Michigan**

Zip: 48909

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 the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Meghan Groen

State Medicaid Director or Designee

Submission Date: Jun 11, 2026

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, Health Services

Address: PO Box 30479

Address 2: 400 South Pine Street

City: Lansing

State: **Michigan**

Zip: 48933

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

Fax: (517) 335-5007

E-mail: GroenM2@michigan.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

MDHHS will allow for a transition timeframe of six months for beneficiaries receiving Prevocational services to transition to a similar service, 1915(i)SPA Skill Building service or Out of Home Non-vocational Habilitation. MDHHS believes the impact for the 9 beneficiaries receiving Prevocational service to be minimal as the six-month transition timeframe will allow beneficiaries to secure another provider if their current provider does not provide 1915(i)SPA Skill Building service or Out of Home Non-vocational Habilitation. MDHHS staff training requirements are the same for Prevocational services, Skill Building and Out of Home Non-vocational Habilitation.

OUT-OF-HOME NON-VOCATIONAL HABILITATION SERVICE IS AVAILABLE UNDER THE HSW. THIS SERVICE PROVIDES ASSISTANCE WITH ACQUISITION, RETENTION, OR IMPROVEMENT IN SELF-HELP, SOCIALIZATION, AND ADAPTIVE SKILLS; AND THE SUPPORTS SERVICES, INCLUDING TRANSPORTATION TO AND FROM, INCIDENTAL TO THE PROVISION OF THAT ASSISTANCE THAT TAKES PLACE IN A NON-RESIDENTIAL SETTING, SEPARATE FROM THE HOME OR FACILITY IN WHICH THE BENEFICIARY RESIDES.

THIS SERVICE IS INTENDED TO ENHANCE SOCIAL DEVELOPMENT AND DEVELOP SKILLS IN PERFORMING ACTIVITIES OF DAILY LIVING AND COMMUNITY LIVING AS SPECIFIED AND FURNISHED CONSISTENT WITH THE BENEFICIARY'S IPOS. THESE SUPPORTS FOCUS ON ENABLING THE BENEFICIARY TO ATTAIN OR MAINTAIN THEIR MAXIMUM FUNCTIONING LEVEL, AND SHOULD BE COORDINATED WITH ANY NEEDED THERAPIES IN THE BENEFICIARY'S PERSON-CENTERED SERVICE PLAN, SUCH AS PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY. SERVICES MAY SERVE TO REINFORCE SKILLS OR LESSONS TAUGHT IN SCHOOL, THERAPY, OR OTHER SETTINGS.

PERSONAL CARE/ASSISTANCE MAY BE A COMPONENT PART OF OUT-OF-HOME NON-VOCATIONAL HABILITATION SERVICES AS NECESSARY TO MEET THE NEEDS OF A BENEFICIARY BUT MAY NOT COMPRISE THE ENTIRETY OF THE SERVICE.

EXAMPLES OF INCIDENTAL SUPPORT INCLUDE:
- AIDES HELPING THE BENEFICIARY WITH MOBILITY, TRANSFERRING, AND PERSONAL HYGIENE FUNCTIONS AT THE VARIOUS SITES WHERE HABILITATION IS PROVIDED IN THE COMMUNITY.
- WHEN NECESSARY, HELPING THE BENEFICIARY TO ENGAGE IN THE HABILITATION ACTIVITIES (E.G., INTERPRETING).

SKILL -BUILDING ASSISTANCE IS AVAILABLE UNDER THE 1915(I)SPA BENEFIT. THIS SERVICE CONSISTS OF ACTIVITIES IDENTIFIED IN THE INDIVIDUAL PLAN OF SERVICE THAT ASSIST A BENEFICIARY TO INCREASE THEIR ECONOMIC SELF-SUFFICIENCY WITH AN EMPHASIS ON DEVELOPING AND TEACHING SKILLS THAT LEAD TO THE INDIVIDUAL COMPETITVE INTEGRATED EMPLOYMENT (ICIE) AND TO DEVELOP SKILLS TO SUCCESSFULLY ENGAGE IN MEANINGFUL ACTIVITIES SUCH AS SCHOOL, WORK, AND/OR VOLUNTEERING. THE SERVICES OCCUR IN COMMUNITY-BASED INTEGRATED SETTINGS WITH INDIVIDUALS WITHOUT DISABILITIES, PROVIDE KNOWLEDGE AND SPECIALIZED SKILL DEVELOPMENT AND/OR SUPPORTS TO ACHIEVE SPECIFIC OUTCOMES CONSISTENT WITH THE INDIVIDUAL'S IDENTIFIED GOALS WITH THE PURPOSE OF FURTHERING HABILITATION GOALS THAT WILL LEAD TO GREATER OPPORTUNITIES OF COMMUNITY INDEPENDENCE, INCLUSION, PARTICIPATION, AND PRODUCTIVITY. SKILL BUILDING ASSISTANCE IS A TIME-LIMITED SERVICE WITH PRIMARY FOCUS ON SKILL DEVELOPMENT, ACQUISITION, RETENTION, OR IMPROVEMENT IN SELF-HELP SOCIALIZATION AND ADAPTIVE SKILLS.
SERVICES INCLUDES TWO PATHWAYS TO SKILL DEVELOPMENT:

1.SKILL BUILDING AS A PATHWAY TO DEVELOP SKILLS TO SUCCESSFULLY ENGAGE IN MEANINGFUL ACTIVITIES SUCH AS SCHOOL, WORK AND/OR VOLUNTEERING INCLUDES THE FOLLOWING:
• DEVELOPING AND TEACHING SKILLS THAT LEAD TO SUCCESSFUL ENGAGEMENT IN MEANINGFUL COMMUNITY-BASED ACTIVITIES, BUT NOT LIMITED TO, ABILITY TO COMMUNICATE EFFECTIVELY WITH INDIVIDUALS IN THE COMMUNITY; GENERALLY ACCEPTED COMMUNITY CONDUCT AND DRESS; ABILITY TO FOLLOW DIRECTIONS; ABILITY TO ATTEND TO TASKS; PROBLEMSOLVING SKILLS AND STRATEGIES; GENERAL COMMUNITY SAFETY; AND MOBILITY TRAINING. MAY ALSO PROVIDE LEARNING EXPERIENCES THROUGH COMMUNITY PARTICIPATION WHERE THE BENEFICIARY CAN DEVELOP GENERAL STRENGTHS AND SKILLS TO ENGAGE IN MEANINGFUL ACTIVITIES.
• ARE EXPECTED TO OCCUR OVER A DEFINED PERIOD OF TIME AND PROVIDED IN SUFFICIENT AMOUNT AND SCOPE TO ACHIEVE THE OUCTOME AND ENCOURAGE FADING TO PROMOTE COMMUNITY INLCUSION, AS DETERMINED BY THE BENEFICIARY AND THEIR CARE PLANNING TEAM IN THE ONGOING PERSON-CENTERED PLANNING PROCESS.

2.SKILL BUILDING AS A PATHWAY ON DEVELOPING AND TEACHING SKILLS THAT LEAD TO THE INDIVIDUAL COMPETITIVE INTEGRATED EMPLOYMENT (ICIE):
• PARTICIPATION IN SKILL-BUILDING IS NOT A REQUIRED PRE-REQUISITE FOR INDIVIDUAL COMPETITIVE INTEGRATED EMPLOYMENT OR RECEIVING SUPPORTED EMPLOYMENT SERVICES
• WORK PREPARATORY (TIME-LIMITED WORK PATHWAY) SERVICES TO ATTAIN ICIE IN THE COMMUNITY IN WHICH AN INDIVIDUAL IS COMPENSATED AT OR ABOVE THE MINIMUM WAGE, BUT NOT LESS THAN THE CUSTOMARY WAGE AND LEVEL OF BENEFITS PAID BY THE EMPLOYER FOR THE SAME OR SIMILAR WORK PERFORMED BY INDIVIDUALS WITHOUT DISABILITIES.
• SERVICES ARE INTENDED FOR THE BENEFICIARY TO DEVELOP, AQUIRE OR IMPROVE SKILLS THAT LEAD TO ICIE. EXAMPLES OF SUCH SKILLS INCLUDE INCLUDING, BUT ARE NOT LIMITED TO; ABILITY TO COMMUNICATE EFFECTIVELY WITH SUPERVISORS, CO-WORKERS AND CUSTOMERS; GENERALLY ACCEPTED COMMUNITY WORKPLACE CONDUCT AND DRESS; ABILITY TO FOLLOW DIRECTIONS; ABILITY TO ATTEND TO TASKS; WORKPLACE PROBLEM SOLVING SKILLS AND STRATEGIES; GENERAL WORKPLACE SAFETY AND MOBILITY TRAINING
• PROVIDE LEARNING AND WORK EXPERIENCES, INCLUDING VOLUNTEERING, WHERE THE INDIVIDUAL CAN DEVELOP GENERAL, NON-JOB-TASK-SPECIFIC STRENGTHS AND SKILLS THAT MAY CONTRIBUTE TO EMPLOYABILITY IN COMPETITIVE INTEGRATED EMPLOYMENT
• ENABLE AN INDIVIDUAL TO ATTAIN INDIVIDUAL COMPETITIVE INTEGRATED EMPLOYMENT AND WITH THE JOB MATCHED TO THE INDIVIDUAL'S INTERESTS, STRENGTHS, PRIORITIES, ABILITIES, AND CAPABILITIES.
• ARE EXPECTED TO OCCUR OVER A DEFINED PERIOD OF TIME AND PROVIDED IN SUFFICIENT AMOUNT AND SCOPE, TO ACHIEVE THE OUTCOME AND ENCOURAGE FADING TO PROMOTE ICIE, AS DETERMINED BY THE BENEFICIARY AND THEIR CARE PLANNING TEAM IN ONGOING PERSON-CENTERED PLANNING PROCESS.

BENEFICIARIES WHO ARE STILL ATTENDING SCHOOL MAY RECEIVE SKILL BUILDING AND OTHER WORK-RELATED TRANSITION SERVICES THROUGH THE SCHOOL SYSTEM WHILE ALSO PARTICIPATING IN SKILL BUILDING SERVICES DESIGNED TO COMPLIMENT AND REINFORCE THE SKILLS BEING LEARNED IN THE SCHOOL PROGRAM DURING PORTIONS OF THEIR DAY THAT ARE NOT THE EDUCATIONALS SYSTEM'S RESPONSIBILITY, E.G., AFTER SCHOOL OR ON WEEKENDS AND SCHOOL VACATIONS.

IF AN INDIVIDUAL HAS A NEED FOR TRANSPORTATION TO PARTICIPATE, MAINTAIN, OR ACCESS THE SKILL-BUILDING SERVICES, THE SAME PROVIDER MAY BE REIMBURSED FOR PROVIDING THIS TRANSPORTATION, ONLY AFTER IT IS DETERMINED THAT IT IS NOT OTHERWISE AVAILABLE (E.G. VOLUNTEER, FAMILY MEMBER) AND IS THE LEAST EXPENSIVE AVAILABLE MEANS SUITABLE TO THE BENEFICIARY'S NEED, IN ACCORDANCE WITH THE MEDICAID PROVIDER MANUAL NON-EMERGENCY MEDICAL TRANSPORTATION POLICY.

THE HEALTH AND WELFARE OF BENEFICIARIES WHO RECEIVE SERVICES THROUGH THE APPROVED WAIVER WILL BE ASSURED BY ALLOWING THE SIX-MONTH TRANSITION TIMEFRAME TO ALLOW FOR BENEFICIARIES TO SECURE ANOTHER PROVIDER IF THEIR CURRENT PROVIDER DOES NOT PROVIDE OUT-OF HOME NONVOCATIONAL SERVICES OR 1915(I)SPA SKILL BUILDING SERVICE.

ANY TIME A SERVICE IS SUSPENDED, TERMINATED OR REDUCED BENEFICIARIES ARE PROVIDED OPPORTUNITY FOR FAIR HEARING WHICH IS DONE THROUGH THE PERSON-CENTERED PLANNING PROCESS. FOR ALL BENEFICIARIES WHICH ARE IMPACTED BY THE REMOVAL OF PREVOCATIONAL SERVICE THE PCP PROCESS WILL BE UTILIZED TO PROVIDE AN OPPORTUNITY FOR FAIR HEARING AND TERMINATION OF THE SERVICE THROUGH THE PERSON-CENTERED PLANNING PROCESS. THE SUPPORTS COORDINATOR WILL EITHER COMPLETE AN INDIVIDUAL PLAN OF SERVICE ADDENDUM OR AN IPOS RENEWAL AT WHICH TIME THE BENEFICIARY WILL BE PROVIDED NOTICE AND THE OPPORTUNITY TO REQUEST FOR HEARING.

Formal communications regarding service language updates will be provided to beneficiaries, community partners and providers regarding all changes to waiver service. ANY TIME A SERVICE IS SUSPENDED, TERMINATED OR REDUCED BENEFICIARIES ARE PROVIDED OPPORTUNITY FOR FAIR HEARING WHICH IS DONE THROUGH THE PERSON-CENTERED PLANNING PROCESS. THE SUPPORTS COORDINATOR WILL EITHER COMPLETE AN INDIVIDUAL PLAN OF SERVICE ADDENDUM OR AN IPOS RENEWAL AT WHICH TIME THE BENEFICIARY WILL BE PROVIDED NOTICE AND THE OPPORTUNITY TO REQUEST FOR HEARING. Updates to the Behavioral Health Code Charts and Provider Qualification as well as the Medicaid Provider Manual will also occur to delineate all changes to waiver service.

ADDITIONAL TRANSITION PLANNING RELATED TO THE AMENDMENT APPLICATION.

IT IS EXPECTED THAT THERE WILL BE NO IMPACT ON SERVICE UTILIZATION AS A RESULT OFUPDATED VALUES AND NARRATIVES CORRESPONDING TO APPENDIX J OF THE RENEWAL APPLICATION INCLUDING PER DIEM RATES FOR COMMUNITY LIVING SUPPORT SERVICES, NON-LICENSED RESIDENTIAL AND OVERNIGHT HEALTH AND SAFETY SUPPORTS.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

THE ADDITION OF THE NEW PERFORMANCE MEASURE TO WAIVER ADMINISTRATION AND OPERATION FOR OVERSIGHT OF HCBS SETTINGS PROTECTIONS WILL ALLOW MDHHS GREATER OVERSIGHT AND ASSURANCE OF BENEFICIARY PROTECTIONS BEING PROVIDED BY THE PIHP/CMHSP.

MDHHS TO ENSURE THAT ALL CASE MANAGERS AND ALL IDENTIFIED INDIVIDUAL PROVIDERS HAVE BEEN TRAINED ON THE HOME AND COMMUNITY BASED SERVICES RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS).
THE ADDITION OF HCBS TRAINING IS REQUIRED AND HAS BEEN ADDED TO PROVIDER QUALIFICATIONS FOR THE FOLLOWING SERVICES.

- CASEMANGERS, INCLUDING ALL WHO SERVE IN THE CASEMANGER ROLE,
- COMMUNITY LIVING SUPPORT,
- SUPPORTED EMPLOYMENT- SMALL GROUP EMPLOYMENT,
- SUPPORTED EMPLOYMENT- INDIVIDUAL SUPPORTED EMPLOYMENT AND
- OUT-OF-HOME NONVOCATIONAL HABILITATION

IMPLEMENTATION OF TRAINING REQUIREMENTS INCLUDES THE FOLLOWING ACTIONS:

- MDHHS CREATED STATE HCBS TRAININGS FOR STAFF IDENTIFIED.
- MDHHS WILL ENSURE EACH PIHP HAS AN IMPLEMENTATION PLAN OF HOW THEY WILL ENSURE STAFF ARE TRAINED. THIS WILL INCLUDE TIMELINES FOR IMPLEMENTATION.
- A TRANSITION PERIOD FOR THE FIRST YEAR WILL BE PROVIDED TO ALLOW TIME FOR REQUIRED TRAINING.
- DURING THIS TIMEFRAME MDHHS WILL PROVIDE TECHNICAL ASSISTANCE FROM MDHHS SITE REVIEW TEAM AND THE HCBS TEAM.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   Michigan Department of Health and Human Services (MDHHS) - HEALTH SERVICES

   (Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

a)As reported in the Brief Waiver Description, MDHHS went through a reorganization in 2019. The Medicaid Services Administration (MSA) who had responsibility for operations and payments, respectively, went through a reorganization and BECAME the Behavioral and Physical Health and Aging Services Administration (BPHASA). Additionally, a new bureau was created with a focus on children's specialty behavioral health services at this time. IN FY 25 BPHASA WENT THROUGH A RESTRUCTURING EFFECTIVE 4/1/2025 AND IS NOW HEALTH SERVICES. HEALTH SERVICES IS THE ADMINISTRATION THAT OVERSEES THE OPERATIONS OF THE HSW. The administration, operation, and oversight of the 1915(c) waivers is now shared across two bureaus: the Bureau of Specialty Behavioral Health Services (BSPBHS) which is under the HEALTH SERVICES and the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). HEALTH SERVICES and BCCHPS continue to operate under MDHHS. More specifically, the MDHHS HEALTH SERVICES performs the following operational and administrative functions: all administrative functions related to the HSW including review and approval of initial waiver applications and annual re-evaluation submitted by Prepaid Inpatient Health Plans (PIHPs), waiver enrollment, preparation of waiver amendments and renewals, completion of annual CMS 372 reports, monitoring for quality assurance safeguards and standards and compliance with all CMS assurances, including financial accountability. Additionally, MDHHS HEALTH SERVICES staff approve or certify some programs, disseminate information concerning the waiver to potential enrollees and service providers, assist individuals in waiver enrollment, manage waiver enrollment against approved limits, monitor waiver expenditures against approved levels, monitor level of care evaluation activities, conduct site reviews, determine waiver managed care average costs per unit, conduct training and technical assistance (including providing input for updating the Medicaid Provider Manual) concerning waiver requirements and implementation.

b)The Michigan Medicaid Provider Manual describes roles and responsibilities for waiver operations by the MDHHS in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Per the MDHHS Organizational Chart, operation of the HSW is within the MDHHS HEALTH SERVICES, Bureau of Specialty Behavioral Health Services(BSBHS).

c)The MDHHS Director oversees and provides guidance related to the administration and operation of the HSW through regular and as-needed (if issues arise) contacts with the directors of MDHHS-HEALTH SERVICES. The bureau director of the Bureau of Specialty Behavioral Health Services (BSBHS) meets with Medicaid director on a monthly schedule to review BSBHS performance which would include HSW guidance/oversight, BSBHS policies, PIHP contract changes and oversight, etc.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the

methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

  Michigan operates a concurrent 1115 Behavioral Health Demonstration with the §1915(c) waiver. MDHHS contracts with regional non-state public managed care entities known as Prepaid Inpatient Health Plans (PIHPs) to conduct operational and administrative functions at the regional and local levels in accordance with the Balanced Budget Act and managed care requirements. Michigan's PIHPs are comprised of one or more Community Mental Health Services Programs (CMHSPs).

  PIHPs are delegated the responsibility to perform the following functions: disseminating information concerning the waiver to potential enrollees; assisting beneficiaries in applying for waiver enrollment; managing waiver slot allocation; compiling information for level of care evaluation and re- certifications; assuring beneficiaries have been given freedom of choice of providers and have consented to HSW services in lieu of ICF/IID; reviewing individual plans of service for appropriateness of waiver services in the amount, scope and duration necessary to meet the beneficiary's needs; conducting prior authorization or utilization management of waiver services; performing quality assurance and quality improvement activities; and maintaining, monitoring and managing the qualified provider network for managed care and HSW services. INCLUDED WITH IN THE PIHP NETWORK ARE CASE MANAGEMENT SERVICES WHICH INCLUDE SUPPORTS COORDINATION AND INTENSIVE CARE COORDINATION WITH WRAPAROUND FOR CHILDREN AND YOUNG ADULTS UP UNTIL THE AGE OF 21. CASE MANAGEMENT SERVICES OR SUPPORTS COORDINATION SERVICES WILL BE REFERENCED AND USED INTERCHANGEABLY THROUGHOUT THE APPLICATION.

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

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

Appendix A: Waiver Administration and Operation

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

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:
  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is

available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Michigan Department of Health and Human Services (MDHHS) is responsible for assessing the performance of the PIHPs in conducting HSW functions.

Appendix A: Waiver Administration and Operation

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

Within MDHHS HEALTH SERVICES, the Division of Adult Home and Community Based Services monitors implementation of the concurrent Michigan 1115 Behavioral Health Demonstration and the §1915(c) HSW. This Division also compiles and analyzes encounter data reported by the PIHPs for services delivered to beneficiaries under Michigan 1115 Behavioral Health Demonstration and §1915(c) HSW services. Within the Division of Adult Home and Community Based Services (AHCBS), the Federal Compliance Section has responsibility for performing on-site reviews at each PIHP. A full on-site review is completed at each PIHP/CMHSP on an annual basis (moved from biennial to annual this waiver renewal STARTING IN FISCAL YEAR 2026 TO HAVE ONE YEAR FOR PREPARATION OF THIS CHANGE), The Site Review Team reviews a random sampling of HSW beneficiaries at each PIHP and any affiliate CMHSPs within a PIHP region as applicable. Those reviews include clinical record reviews and beneficiary interviews using the Site Review Protocols. The protocols are derived from requirements of the Michigan Mental Health Code, Administrative Rules, federal requirements, and Medicaid policies. The Site Review team monitors the following of the PIHP delegated responsibilities: 1) individual plans of service (IPOS) meet the HSW beneficiaries identified needs for habilitation; 2) needed services are provided in the amount, scope and duration defined in the IPOS, including any PIHP prior authorization and/or utilization management functions that were part of the allocation of services; 3) provider qualifications and adequacy of the provider network available for HSW beneficiaries; AND 4) FOR BENEFICIARIES RESIDING IN A SPECIALIZED RESIDENTIAL SETTING/ ADULT FOSTER CARE SETTING A SUMMARY OF RIGHTS DOCUMENT HAS BEEN PROVIDED TO AND SIGNED BY THE BENEFICIARY OR LEGAL REPRESENTATIVE. The Site Review Team also conducts a follow-up review approximately 90 days after the Corrective Action Plan has been approved to assess the status and effectiveness of the individual remediations implemented by the PIHP/CMHSP. Implementation of systemic remediations will be reviewed at the next annual PIHP/CMHSP site review to ensure all systemic concerns have been addressed as identified in the CAP. The Division of Adult Home and Community Based Services (AHCBS) oversees all quality improvement efforts and ongoing quality assurance by the PIHPs.

Within MDHHS HEALTH SERVICES, the Bureau of Specialty Behavioral Health Services has responsibility for operation of the HSW on a day-to-day basis. The HSW Program staff from the Federal Compliance Section, on a continual basis, monitor the following PIHP delegated responsibilities: 1) reviewing quality of individual plans of service (IPOS) using person-centered planning (PCP) process and appropriateness for HSW eligibility; 2) reviewing and approving PIHP recommendations for involuntary disenrollments from the HSW; 3) monitoring timeliness of freedom of choice in lieu of ICF/IID services completed at least every three years; and 4) monitoring health and welfare issues by way of recipient rights complaints, critical incidents, Medicaid fair hearing requests, and the use of restrictive or intrusive behavioral interventions.

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

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 BENEFICIARIES WITH AN AUTHORIZED SERVICE PLAN AND HAVE RECEIVED SERVICE WITHIN 14 DAYS OF THE AUTHORIZATION START DATE. NUMERATOR: NUMBER OF SERVICE PLANS REVIEWED, DENOMINATOR: NUMBER OF SERVICE PLANS THAT REFLECT SERVICE RECEIVED WITHIN 14 DAYS OF THE AUTHORIZATION START DATE.

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 = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 PIHPs implementing prior authorization according to established policy. Numerator: Number of PIHPs implementing prior authorization according to policy. Denominator: All PIHPs reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: sampling methodology determined by EQR
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
NUMBER AND PERCENT OF BENEFICIARIES WHO RESIDE IN A SPECIALIZED RESIDENTIAL SETTING ADULT FOSTER CARE AND HAVE A SIGNED SUMMARY OF RIGHTS DOCUMENT. NUMERATOR: NUMBER OF BENEFICIARIES WITH A SIGNED SUMMARY OF RIGHTS DOCUMENT. DENOMINATOR: NUMBER OF ALL HSW BENEFICIARIES RESIDING IN A SPECIALIZED RESIDENTIAL ADULT FOSTER CARE SETTING.

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

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

Data Aggregation and Analysis:

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

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.

The MDHHS site review process includes a full review on an annual basis and a follow-up review 90 days after the corrective action plan is approved. For performance measures related to timely remediation of issues of level of care, plan of service, and qualified providers, AND SIGNED SUMMARY OF RIGHTS DOCUMENT, the same proportionate random sample used for the review is used. The data source is the plan of correction remediation evidence submitted by the PIHP/CMHSP for any issues identified during the review of the sample. Timely remediation is completed within 90 days after the PIHP/CMHSP's plan of correction has been approved by MDHHS for individual remediation and at the next annual PIHP/CMHSP site review for systemic remediation.

For the performance measure related to the delegation of managing expenditures against approved limits, under expenditure is monitored through a proxy measure of the percent of filled slots at each PIHP. The data source is the HSW database, which has a report for slot allocation/utilization which calculates the percentages of slots filled. The methodology is a review of all PIHPs on a monthly basis.

For the performance measure related to utilization management, a strong proxy indicator that utilization management problems may be present is the volume and type of hearings. The methodology for this measure is to review all hearing decision and order documents related to PIHP utilization management decisions for HSW beneficiaries.

Michigan's concurrent §1115 Behavioral Health Demonstration/1915(c) waiver includes a comprehensive quality improvement program that includes beneficiaries from the HSW, the Children's Waiver, the Waiver for Children with Serious Emotional Disturbances and the 1915(i) SPA. PIHPs are required to submit data on a quarterly basis on Performance Indicators specified by MDHHS. These indicators are used to identify trends, outliers, and potentially, may be used for performance improvement programs. The EQR is an additional strategy employed by the State to discover problems and identify trends. EQR activities primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. One EQR component addresses PIHP compliance to Balanced Budget Act (BBA) requirements. The other two EQR activities - Performance Improvement Program Validation and Performance Indicators Validation - provide a mechanism for discovering problems / issues.

The MDHHS site review team also conducts a comprehensive administrative review focused on policies, procedures, and initiatives that are not otherwise reviewed by the External Quality Review (EQR) and need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, and customer complaints.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

As described in a.ii. above, a standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs/CMHSPs which are required to submit plans of correction to MDHHS HEALTH SERVICES within 30 days. The plans of correction are reviewed by staff that completed the site review and are subsequently reviewed and approved by MDHHS. The PIHP/CMHSPs has 90 days after the plan of correction has been approved to provide evidence to MDHHS that all individual issues have been remediated. The implementation of systemic remediations is reviewed at the next annual PIHP/CMHSP site review to ensure all concerns have been appropriately addressed. The remediation process continues until all concerns have been appropriately addressed. If the PIHP/CMHSP is having difficulty meeting the timeframes for remediation, MDHHS staff will work with the PIHP/CMHSPs to identify strategies to improve timeliness.

If individual issues are noted as a result of review of any of the administrative authority performance measures, MDHHS will contact the PIHP/CMHSP and monitor to assure the PIHP/CMHSPs addresses concerns.

Remediation for slot utilization occurs when a PIHP has a filled slot percentage of 95% or lower for three consecutive months. If that occurs, the HSW program staff contact the PIHP and offer technical assistance to the supports coordinators and QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP) to help them identify potentially eligible Medicaid beneficiaries and how to complete LEVEL OF CARE (LOC) evaluations.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ 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:

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	8268
Year 2	8268
Year 3	8268
Year 4	8268
Year 5	8268

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	7902
Year 2	7902
Year 3	7902
Year 4	7902
Year 5	7902

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).**

Purpose(s) the state reserves capacity for:

Purposes	
Enrollment of Priority Groups	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Enrollment of Priority Groups

Purpose *(describe):*

The MDHHS retains 7 slots for a temporary enrollment in the HSW for individuals who ARE IDENTIFIED AS A PRIORITY ENROLLMENT GROUP : 1) CHILDREN'S WAIVER PROGRAM (CWP) BENEFICIARIES WHO ARE DISENROLLING FROM THE CWP AT THE END OF THEIR 18TH BIRTHDAY MONTH; 2) PEOPLE APPLYING TO THE HSW WHO ARE AGE 21 AND OLDER, WHO REQUIRE PRIVATE DUTY NURSING SERVICES AND MEET ALL OTHER ELIGIBILITY REQUIREMENTS FOR HSW ENROLLMENT; AND 3) PEOPLE WHO ARE AT IMMINENT RISK OF BEING PLACED IN THE ICF/IID. The temporary slots are loaned to a PIHP WHEN A PIHP DOES NOT HAVE A SLOT AVAILABLE until the PIHP has a vacancy within its allocation. At that point, the beneficiary is assigned by HSW Program staff into the available PIHP slot and the MDHHS slot is returned to the pool for re-use.

Describe how the amount of reserved capacity was determined:

Highest priority of entrants into the HSW is as follows: 1) Children's Waiver Program (CWP) participants who are aging off from the CWP at the end of their 18th birthday month (approx. 20-30 people annually after consideration of Medicaid eligibility); 2) people applying to the HSW who are age 21 and older, who require private duty nursing services and meet all other eligibility requirements for HSW enrollment (approx. 10 people annually); and then 3) people who are at imminent risk of being placed in the ICF/IID (approx. 10 people annually). To ensure no delay in services for the priority groups, MDHHS determined that a small bank of slots should be retained at the State to loan temporarily to a PIHP that did not have a vacancy at the time of enrollment. The calculation of 7 slots was based on 15% of the people from the three priority groups (approximately 40-50 people annually).

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	7
Year 2	7
Year 3	7
Year 4	7
Year 5	7

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) Slots are allocated to each PIHP.

b) The methodology for determining the number of slots each PIHP was issued is based on several factors, including the following:

- Maximum number of slots filled by region in the past 15 months based upon self-reported MDHHS data
- Self-reporting of eligible individuals currently on a PIHP's waiting list
- Penetration rate for each PIHP of persons served with intellectual/developmental disabilities compared to the number of HSW slots allocated, assuming a minimum penetration rate of 95% for every PIHP
- Input from PIHPs that either are requesting additional HSW slots or have unused capacity
- Monitoring the usage by PIHP on the HSW database

The distribution of slots among the PIHPs is re-evaluated at least annually or more frequently if necessary. The HSW staff oversee the procedure to assist beneficiaries who move from one PIHP to another in order to assure continuity of services. The procedure requires that the current and future PIHP HSW coordinators are notified of the impending move as soon as the move is known. The directors of both PIHPs must submit a letter to the Federal Compliance Section Manager indicating their awareness of the move and assuring continuity of services for the HSW beneficiary. At the time of the move, the beneficiary's enrollment is transferred to the new PIHP by way of the HSW database slot allocation report which is controlled by the HSW Program staff at the state level. If there is no vacancy at the new PIHP, the slot is loaned from the current PIHP to the new PIHP by way of the HSW database. As an alternative to a temporary loan/borrow arrangement, the two PIHP directors may also negotiate a permanent transfer of a slot for the beneficiary in writing to the Federal Compliance Section Manager. THIS PROCESS ASSURES THAT WAIVER SLOTS ARE PORTABLE ACROSS THE STATE, ENSURING BENEFICIARIES HAVE FREE MOVEMENT FROM AREA TO AREA WITHIN THE STATE.

ON A MONTHLY BASIS MDHHS REVIEWS SLOT ALLOCATION AND UTILIZATION. IN SITUATIONS WHERE PIHPS HAVE INDIVIDUALS WAITING FOR AN OPEN SLOT, MDHHS WILL WORK WITH THAT PIHP TO EVALUATE WHETHER REALLOCATION OF HSW SLOTS FROM ANOTHER PIHP WITH UNUSED CAPACITY IS NECESSARY TO MEET THESE NEEDS. CURRENT AND PAST HSW SLOT UTILIZATION WILL BE ANALYZED TO ENSURE THE PIHP WITH UNUSED CAPACITY DOES NOT HAVE INDIVIDUALS WHO MEET OUR PRIORITY HSW ENROLLMENT POPULATION.

THE PIHP'S WILL REPORT MONTHLY ANY INDIVIDUALS WAITING FOR HSW ENROLLMENT DUE TO LACK OF CAPACITY OF SLOTS AVAILABLE. MDHHS WILL REALLOCATE SLOTS FOR INDIVIDUALS WHO ARE IN NEED OF HSW ENROLLMENT BUT THERE ARE NO SLOTS AVAILABLE within the PIHP.

Highest priority of entrants into the HSW based upon the following hierarchy: 1) Children's Waiver Program (CWP) beneficiaries who are disenrolling from the CWP at the end of their 18th birthday month; 2) people applying to the HSW who are age 21 and older, who require private duty nursing services and meet all other eligibility requirements for HSW enrollment; and 3) people who are at imminent risk of being placed in the ICF/IID.

c) Annual reallocation of slots follows the methodology described above in which PIHPs self-report to MDHHS monthly slot usage as well as input on unused capacity or greater need. The BSBHS Federal Compliance Section Manager and staff monitor slot utilization by PIHP on a monthly basis and work with any PIHPs that are less than 95% filled for three consecutive months by providing technical assistance, regional training, and on-site record reviews to assist staff in identifying and applying for HSW enrollment on behalf of individuals who are eligible.

Since private duty nursing for age 21 and older is not available in the State Plan, MDHHS may loan a slot to the PIHP until a vacancy occurs, then move the beneficiary into that PIHP slot and return the loaned slot to the State reserved pool for re-use. This will ensure no delay in service for those applicants in priority group 2 (beneficiary age 21 and older who needs private duty nursing).

The HSW uses an application management process to closely manage utilization through enrollments against the appropriations. The PIHPs are responsible for entering disenrollments into the web-based HSW database and can monitor their utilization of enrollment slots through a report in the database in real time. As a vacancy occurs, the PIHP HSW Coordinator submits an application packet to re-fill that vacancy in the next month after the slot became

available. The HSW program staff enroll eligible applicants as slots become vacant in this manner up to the approved limit noted in B.3.a.

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

The selection of entrants into the HSW is made at the state level. The procedure for enrollment begins at the PIHP. Each PIHP has an HSW Coordinator, who has primary responsibility for working with supports coordinators and potential enrollees to identify those beneficiaries for whom the PIHP will submit an application. Identification of prospective applicants may come directly from the beneficiary or his/her family requesting the HSW or from the supports coordinator or other staff at the PIHP/CMHSP/other subcontractor. A clinical SCREENING tool like the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 (for adults 18 and over) or Michigan Child and Adolescent Needs and Strengths (MichiCANS)(for children up to the age of 18) appropriate for beneficiaries with I/DD can be used to identify potential enrollees to HSW. MDHHS will begin utilizing a SCREENING TOOL for all beneficiaries with I/DD to identify those who may meet ICF LOC criteria to assist the PIHP/CMHSP/other subcontractor to identify potential enrollees onto the HSW. The use of this new I/DD assessment will improve the identification of beneficiaries who may have a need for HSW services prior to the formal enrollment process. Additionally, many of the PIHPs have a clinical committee that reviews records to identify those Medicaid beneficiaries who meet the HSW eligibility requirements. The HSW Coordinators have participated in numerous training and technical assistance opportunities and are well-versed in the HSW eligibility requirements. This training enables the HSW Coordinators to be able to explain the waiver and its requirements to clinicians, supports coordinators, prospective applicants and families. In addition, the MDHHS/PIHP contract requires that each PIHP have a customer services office, where recipients of mental health services can obtain information on services, including the HSW. THE PIHP CONTRACT GOVERNS THE PROCESS AND THE TOOLS REQUIRED IN ORDER TO PROCESS AND SUBMIT HSW APPLICATIONS. If the PIHP determines that an application will be submitted for a Medicaid beneficiary, the HSW Coordinator compiles the required documentation to submit to MDHHS. Required documentation consists of a completed HSW certification form, the current plan of services, documentation regarding the person's functional skills (Performance on Areas of Major Life Activities form), and any relevant supporting documentation such as professional assessments, individual educational plans (IEP) from schools, or medical reports. If the PIHP determines that an application will not be submitted or will be delayed in submission, the PIHP must give the Medicaid beneficiary an adequate notice of right to fair hearing to appeal that decision.

Once the PIHP submits an application to MDHHS, the Federal Compliance Section staff begin the review process. Michigan uses the Code of Federal Regulations (42 CFR 483.400 and 42 CFR 442 Subpart C) as the basis for evaluations of the beneficiary's need for the ICF/IID level of care (but for the availability of home and community-based services). Each application is reviewed by a QIDP (qualifications for these staff are noted in B.6.c of this application), who completes a worksheet within the secure web-based HSW database that addresses each of the HSW eligibility requirements: Presence of an intellectual/developmental disability; Medicaid eligibility; priority population, community residence, need for HSW services with amount, scope, and duration of HSW services to be provided if approved. The reviewing QIDP at MDHHS then makes a decision, based on the information contained in the application, to either approve, deny, or pend the application for additional information.

If approved, the HSW Program staff prioritizes enrollment of eligible applicants by giving first available vacant slots in a PIHP to a member of one of the priority populations specified in B.3.c and then, by date received within the PIHP's applications (first in, first approved). As noted previously, if a member of a priority group is eligible for enrollment but the PIHP does not have any slots available, one of the reserved slots is issued to the PIHP until a vacancy occurs. When approved, the PIHP receives the signed certification form from the secured web-based HSW database.

If denied, the Medicaid beneficiary or his/her legal representative is issued an adequate notice of right to fair hearing.

If pended, the application is sent back to the PIHP, and staff communicate to the PIHP HSW Coordinator about what documentation is lacking via the secure web-based HSW database. An offer is made at that time by the HSW Program staff to provide telephone consultation with the supports coordinator and HSW Coordinator. This process has helped improve understanding of the HSW requirements and facilitated receipt of additional information to continue the enrollment review process. Once the additional information is received, the QIDP again reviews the application and determines whether to approve enrollment or deny. While the application is in pending status, the beneficiary continues to receive all medically necessary mental health services using the Specialty Mental Health Supports and Services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- (•) **No**
- ( ) **Yes**

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

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

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 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)**
- [x] **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:

Parents & caretaker relatives
42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

Pregnant Women
42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Infants and Children
42 CFR 435.118
1902(a)(10)(A)(i)(III)(IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

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:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near

future (one month or less), but for the availability of home and community-based waiver services.

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

MDHHS personnel with responsibility for conducting the LOC evaluations and reevaluations are Qualified Intellectual Disability Professional (QIDP). A QIDP is an individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, or a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.

The initial evaluation and re-evaluation of the beneficiary's LOC is reviewed and approved by the MDHHS HSW Program staff who are QIDPs or who are obtaining QIDP designation under the direct supervision and co-signature of a QIDP.

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

Medicaid beneficiaries evaluated for the HSW must meet the level of care criteria for an ICF/IID as specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. and as identified in the Michigan Medicaid Provider Manual (MPM). The MPM states in section 3 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter: "Beneficiaries must meet ICF/IID level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a Qualified Intellectual Disability Professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications."

THE LEVEL OF CARE INSTRUMENT UTILIZED IS THE PERFORMANCE ON AREAS OF MAJOR LIFE ACTIVITIES (PMLA) TOOL DEVELOPED BY MDHHS. THE PMLA WHICH ASSESSES A BENEFICIARY'S FUNCTIONAL SKILL PERFORMANCE IN 13 LIFE DOMAINS. A BENEFICIARY MUST BE ASSESSED AS REQUIREING A MINIMUM OF EXTENSIVE SUPPORT NEEDS IN AT LEASE THREE DOMAINS TO BE DETERMINED THAT INTERMEDIATE CARE FACILITY LEVEL OF CARE (ICF LOC) NEEDS ARE PRESENT. A QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL COMPLETES THE PMLA UTILIZING DIRECT OBSERVIATION, INTERVIEWS, CLINICAL ASSESSMENTS, OR OTHER RELEVANT TOOLS.

THE PMLA IS ONE PIECE OF REQUIRED DOCUMENTATION UTILIZED DURING THE INITIAL EVALUATION PROCESS TO DETERMINE WHETHER A BENEFICIARY NEEDS SERVICES THROUGH THE WAIVER. ADDITIONAL DOCUMENTATION INCLUDES A COMPLETED HSW CERTIFICATION FORM, THE CURRENT INDIVIDUAL PLAN OF SERVICE, AND ANY RELEVANT SUPPORTING DOCUMENTATION SUCH AS PROFESSIONAL ASSESSMENTS, INDIVIDUAL EDUCATIONS PLANS(IEP) FROM SCHOOLS, OR MEDICAL REPORTS. THE INITIAL EVALUATION OF THE BENEFICIARY'S LOC IS REVIEWED AND APPROVED BY THE MDHHS HSW PROGRAM STAFF WHO ARE QIDPS OR WHO ARE OBTAINING QIDP DESIGNATION UNDER THE DIRECT SUPERVISION AND CO-SIGNATURE OF A QIDP.

DOCUMENTATION SUBMITTED TO MDHHS FOR REEVALUATIONS CONSISTS OF THE COMPLETED PMLA WHICH REQUIRES A MINIMUM OF EXTENSIVE SUPPORT NEEDS IN AT LEAST THREE DOMAINS TO BE DETERMINED THAT ICF LOC NEEDS ARE PRESENT, HSW CERTIFICATION FORM AND THE CURRENT INDIVIDUAL PLAN OF SERVICE.

Additionally, the eligibility requirements that relate to level of care include: The person must have an intellectual/developmental disability, and if not for the HSW services, would otherwise require ICF/IID level of care services.

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:

Information for initial evaluation of LOC may be gathered at any time by the PIHPs at the request of a Medicaid beneficiary or when professional assessments identify a potential need for HSW services. When vacancies are available at the PIHP, the HSW Coordinator will submit the LOC information as part of the HSW application AS SPECIFIED ABOVE IN B-3-F AND B-6-D. Applications received prior to the 16th of the month are processed for enrollment that month; applications received on and after the 16th of the month are processed for enrollment in the following month. Applications for the groups identified for prioritization are reviewed within five working days and if there is an emergency need to enroll a beneficiary who requires private duty nursing and without enrollment into the HSW would be at risk for health and welfare, the application is reviewed within one working day. If an application is pended by MDHHS for additional information, the PIHP must respond within 15 days or request an extension to gather the information. It is in the beneficiary's best interest to allow additional time when the information submitted with the application is insufficient to support enrollment in the HSW. With technical assistance, most applications are approved once the additional information is provided. IF NO VACANCIES ARE AVAILABLE, THE PIHP HOLDS THE APPLICATION UNTIL A SLOT BECOMES AVAILABLE. APPLICATIONS ONLY PROCEED TO MDHHS FOR REVIEW IF A VACANT SLOT IS AVAILABLE FOR ENROLLMENT. IF BENEFICIARY IS IN NEED OF SERVICES THAT ARE ONLY AVAILABLE ON THE HSW MDHHS WILL LEND A MDHHS SLOT TO THE PIHP UNTIL THE PIHP HAS AN AVAILABLE SLOT.

Services commence immediately upon approval and enrollment in the HSW as the PIHPs have access to real-time enrollment information via the web-based HSW database.

Once the initial determination has been made that the beneficiary has an intellectual/developmental disability, the subsequent re- evaluations of LOC do not require that the presence of I/DD be again determined. The PIHP HSW Coordinator will compile and submit the LOC re-evaluation information with other required documentation to MDHHS within one year of the previous evaluation. MDHHS re-evaluates and determines continued eligibility (including LOC reevaluation). The HSW eligibility certification form documents that the person continues to otherwise need ICF/IID level of care but for the availability of HSW services on.

Personnel from MDHHS with responsibility for conducting the LOC evaluation and reevaluations are Qualified Intellectual Disability Professional (QIDP).

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs

to ensure timely reevaluations of level of care *(specify):*

The web-based HSW database tracks timeliness of re-evaluations through several processes and contains edits in the system to prevent user errors on timelines. The PIHP is responsible for monitoring the re-evaluation dates in the web-based HSW database. The system automatically generates the end-date, so the PIHP is always aware of when the next re-evaluation is due. There are "tickler" reports that the PIHP can generate to identify those re-evaluations coming due in 60 days and 30 days, as well as a report for overdue re-evaluations. The system is designed so the PIHP must account for every day, meaning if a re-evaluation date occurs beyond the 365th day, the PIHP must report a "recertification missing" entry. Because FFP cannot be used if the beneficiary does not meet HSW eligibility, the web-based HSW database is designed to prevent the entry of a re-evaluation while the beneficiary is not residing in a community-based setting, e.g., nursing facility or ICF/IID. In those situations, there will be a gap in re-evaluation dates while the beneficiary was ineligible for HSW services.

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

The PIHP maintains clinical records, including the HSW initial evaluation and re-evaluations of level of care, as well as any supporting documentation. The MDHHS retains a copy of the initial enrollment application, which would include the initial level of care certification. If an application is denied, a copy of the fair hearing notice to the applicant or legal representative is sent to the PIHP for inclusion in the applicant's clinical record and a copy is retained at MDHHS. All records are retained for a minimum period of three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of beneficiaries with IDD with reasonable indication that waiver services may be needed in the future and have an evaluation completed. Numerator: All Beneficiaries with IDD not enrolled in the waiver with reasonable indication that

waiver services may be needed in the future and have an evaluation completed.
Denominator: All beneficiaries with IDD not enrolled in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial LOC evaluation documentation

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled participants whose LOC evaluations are completed within 365 days of the previous evaluation. Numerator: Number of enrolled participants with LOC evaluations completed within 365 days of the previous evaluation. Denominator: All enrolled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial LOC evaluations that are completed by a QIDP.
Numerator: Number of initial LOC evaluations that are completed by a QIDP.
Denominator: All LOC evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial LOC evaluation documentation

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of LOC annual re-evaluations that are documented on the HSW certification form. Numerator: Number of LOC re-evaluations that are documented on the HSW certification form. Denominator: All LOC re-evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC re-evaluation documentation

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of LOC re-evaluations that are completed by a QIDP.
Numerator: Number of LOC re-evaluations that are completed by a QIDP.
Denominator: All LOC re-evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Re-evaluation LOC documentation

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial LOC evaluations that are documented on the HSW certification form. Numerator: Number of initial LOC evaluations that are documented on the HSW certification form at the time of initial application for HSW. Denominator: All LOC evaluations.

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

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 PERCENTAGE OF IPOS COMPLIANCE ISSUES THAT WERE REMEDIATED WITHIN 90 DAYS. NUMERATOR: NUMBER OF IPOS COMPLIANCE ISSUES REMEDIATED WITHIN 90 DAYS. DENOMINATOR: ALL IPOS COMPLIANCE ISSUES.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
NUMBER AND PERCENTAGE OF COMPLETED INDIVIDUAL PLANS OF SERVICE (IPOS) THAT REFLECT PROVIDER SEPARATION OF SERVICE PLANNING FROM SERVICE DELIVERY. NUMERATOR: COMPLETED IPOS WITH THAT REFLECT PROVIDER SEPARATION OF SERVICE PLANNING FROM SERVICE DELIVERY. DENOMINATOR: ALL COMPLETED IPOS.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

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

Data Aggregation and Analysis:

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

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 Federal Compliance Section conducts the LOC evaluation and re-evaluation. Data regarding re-evaluation may also be drawn from HSW database overdue reports, which are reviewed by the Federal Compliance Section staff.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The MDHHS site review process includes a full review on an annual basis and a follow-up review 90 days after the corrective action plan is approved. For performance measures related to timely remediation of issues of level of care, plan of service, and qualified providers, the same proportionate random sample used for the review is used. The data source is the plan of correction remediation evidence submitted by the PIHP/CMHSP for any issues identified during the review of the sample. Timely remediation is completed within 90 days after the PIHP/CMHSP's plan of correction has been approved by MDHHS for individual remediation and at the next annual PIHP/CMHSP site review for systemic remediation.

The HSW database is used to communicate electronically with the PIHPs regarding questions or issues on beneficiary LOC determinations that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information to make the LOC decision. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days.

Any problems noted with initial, or re-evaluation of LOC will be addressed in writing to the PIHP with a plan of correction required to be submitted within 30 days.

Issues with overdue re-evaluations are addressed with the PIHP by way of communication with the HSW coordinator. If the issue relates to a particular beneficiary, which might occur if a guardian does not return paperwork in time, the PIHP identifies a plan of correction to address that beneficiary for future re- evaluations. If a trend is noted, a system-wide plan of correction is submitted by the PIHP to the HSW staff, which monitors for improvement and compliance.

Additionally, during its annual site visits, the MDHHS Site Review Team, which includes several QIDPs, reviews HSW records. If, during its review, a team member notes issues about the accuracy of the LOC decision, the PIHP must submit a copy of the current IPOS for review by the HSW program staff, who will consult with the PIHP and either assist the PIHP with correcting the IPOS to demonstrate the LOC or to determine the person no longer meets HSW eligibility for LOC and needs to disenroll. Issues identified by the Site Review Team are documented on the Site Review Protocol and a report of findings is issued to the PIHP/CMHSP. The PIHP/CMHSP is required to respond to MDHHS's site review report within 30 days of receipt of the report with a plan of correction. This plan of correction must be reviewed and approved by MDHHS staff that completed the site review and by MDHHS administration. The remediation process continues until all concerns have been appropriately addressed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The supports coordinator, supports coordinator assistant, or the independent supports broker are required to provide beneficiaries choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. Supports Coordination services are available to HSW beneficiaries through the State Plan.

The HSW eligibility Certification form is also used to document freedom of choice. This section is completed by the beneficiary, legally responsible adult (typically the parent of a minor aged child), legal guardian or other legal representative with authority to make such decisions on behalf of the beneficiary. By signing the form, the beneficiary, family and/or legal representative verifies that they have been informed of their right to choose between the community based services provided by the HSW and the level of care that would be provided in an ICF/IID.

The beneficiary or his/her legal representative consent to receiving HSW in lieu of ICF/IID level of care at the time of initial application and give consent at least every three years thereafter.

The HSW Eligibility Certification form is maintained in the beneficiary's clinical record at the PIHP. THE PIHP ENSURES THE BENEFICIARY AND /OR GUARDIAN IS PROVIDED A COPY OF THE COMPLETED HSW ELIGIBILITY CERTIFICATION UPON ENROLLMENT AND SUBSEQUENT RE-EVALUATIONS. MDHHS retains a copy of the initial certification form that is completed for enrollment into the HSW.

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

As stated above, Freedom of Choice is part of the HSW eligibility certification form and is maintained by the PIHP in the beneficiary's record. The MDHHS retains a copy of the initial certification form. All forms are retained for a minimum of three years.

Appendix B: Participant Access and Eligibility

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

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

The contract between MDHHS and the PIHPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with intellectual/developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. The contract does specifically require that PIHPs must address cultural differences within its region by making materials available in the languages appropriate to the SPECIFIC INDIVIDUAL TO AID THEM TO ACCESS AND USE SERVICES IN ACCORDANCE WITH 42 CFR 435.905(b)

In the MDHHS/PIHP contract, Schedule A: Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services shall meet the following standards:
1. All such materials shall be written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 6.9 grade level criteria).
2. All materials must be in an easily understood language and format and use a font size no smaller than 12 point.
3. All informative materials, including the provider directory, must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on Contractor's website, in a machine-readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after Contractor receives updated provider information.
4. All materials shall be available in the languages appropriate to the people served within Contractor's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in Contractor's Region. Such materials must be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2000, Federal Register Vol. 65, August 16, 2000). All such materials must be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries must be informed of how to access the alternative formats.

The MDHHS/PIHP contract, Schedule A, requires that the PIHP shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects persons with Limited English Proficiency. This guidance clarifies responsibilities for providing language assistance under Title VI of the Civil Rights Act of 1964.

The MDHHS/PIHP contract, Schedule A, also requires that any subcontracts executed by the PIHP must address compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency".

The MDHHS/PIHP contract also requires that services must be designed and delivered that respond to a beneficiary's ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided.

Each PIHP/CMHSP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP/CMHSP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHP/CMHSP access system. The customer services staff must be trained to welcome people to the public mental health system and to possess current working knowledge or know where in the organization detailed information can be obtained regarding a number of areas, including Limited English Proficiency and cultural competence.

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

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	Out-of-Home Non-Vocational Habilitation		
Statutory Service	Respite		
Statutory Service	SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT		
Extended State Plan Service	Enhanced Medical Equipment and Supplies		
Extended State Plan Service	Enhanced Pharmacy		
Extended State Plan Service	VEHICLE MODIFICATION		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Goods and Services		
Other Service	Community Living Supports		
Other Service	Environmental Modifications		
Other Service	Family Training		
Other Service	Non-Family Training		
Other Service	Overnight Health and Safety Support		
Other Service	Personal Emergency Response System		
Other Service	Private Duty Nursing		
Other Service	SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT		

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:

Habilitation

Alternate Service Title (if any):

Out-of-Home Non-Vocational Habilitation

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides. THIS SERVICE IS PROVIDED IN A COMMUNITY SETTING.

THIS SERVICE IS INTENDED TO ENHANCE SOCIAL DEVELOPMENT AND DEVELOP SKILLS IN PERFORMING ACTIVITIES OF DAILY LIVING AND COMMUNITY LIVING AS SPECIFIED AND FURNISHED CONSISTENT WITH THE BENEFICIARY'S IPOS.

THESE SUPPORTS FOCUS ON ENABLING THE BENEFICIARY TO ATTAIN OR MAINTAIN THEIR MAXIMUM FUNCTIONING LEVEL AND SHOULD BE COORDINATED WITH ANY NEEDED THERAPIES IN THE BENEFICIARY'S PERSON-CENTERED SERVICE PLAN, SUCH AS PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY. SERVICES MAY SERVE TO REINFORCE SKILLS OR LESSONS TAUGHT IN SCHOOL, THERAPY, OR OTHER SETTINGS.

PERSONAL CARE/ASSISTANCE MAY BE A COMPONENT PART OF OUT-OF-HOME NON-VOCATIONAL HABILITATION SERVICES AS NECESSARY TO MEET THE NEEDS OF A BENEFICIARY BUT MAY NOT COMPRISE THE ENTIRETY OF THE SERVICE.

Examples of incidental support include:
- Aides helping the beneficiary with mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.
- When necessary, helping the beneficiary to engage in the habilitation activities (e.g., interpreting).

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

Services must be furnished on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service.

DIFFERENT TYPES OF NON-RESIDENTIAL HABILITATION SERVICES MAY NOT BE BILLED DURING THE SAME PERIOD OF THE DAY.

OUT-OF-HOME NON-VOCATIONAL HABILITATION SERVICES MAY NOT PROVIDE FOR THE PAYMENT OF SERVICES WHICH ARE VOCATIONAL IN NATURE.

MEALS ARE NOT PROVIDED AS A PART OF OUT-OF-HOME NON-VOCATIONAL SERVICES.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Community based program operated by CMHSP or other subcontractor
Agency	staffing agency, home care agency or other subcontractor
Individual	Aide

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out-of-Home Non-Vocational Habilitation

Provider Category:

Agency

Provider Type:

Community based program operated by CMHSP or other subcontractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Community based program sites must be approved by MDHHS prior to delivery of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency must assure that all employees delivering the service meet the provider qualifications specified in the Behavioral Health Code Charts and Provider Qualifications. If the agency is hired directly by a beneficiary through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out-of-Home Non-Vocational Habilitation

Provider Category:

Agency

Provider Type:

staffing agency, home care agency or other subcontractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications as specified in the Behavioral Health Code Charts and Provider Qualifications. If the agency is hired directly by a beneficiary through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Out-of-Home Non-Vocational Habilitation

Provider Category:

Individual

Provider Type:

Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS. AIDES MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP must verify provider qualifications. If the provider is hired directly by a beneficiary through a self-determination arrangement, the PIHP may delegate responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). Intermittent means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. Primary caregivers are typically the same people day after day who provide at least some unpaid supports. Unpaid means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports, or other services of paid support or training staff, should be used. The beneficiary's record must clearly differentiate respite hours from community living support services.

Decisions about the methods and amounts of respite are decided during the person-centered planning process and are specified in the individual plan of service.

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

Respite services may be provided in the following settings that are approved by the beneficiary and identified in the individual plan of services:
-Beneficiary's home
-Home of a friend or relative (not the parent of a minor or the spouse of the beneficiary or the legal guardian)
-Licensed foster care home or respite care facility
-Licensed foster family home or licensed foster family group home
-Licensed Children's Therapeutic group home

-Licensed camp
-In community settings accompanied by a respite worker

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

FEDERAL FINANCIAL PARTICIPATION IS NOT TO BE CLAIMED FOR THE COST OF ROOM AND BOARD EXCEPT WHEN PROVIDED AS PART OF RESPITE CARE FURNISHED IN A FACILITY APPROVED BY THE STATE THAT IS NOT A PRIVATE RESIDENCE. Respite is not covered if the care is being provided in an institution (i.e., ICF/IID, nursing facility, or hospital). RESPITE CARE MAY NOT BE FURNISHED FOR THE PURPOSE OF COMPENSATING RELIEF OR SUBSTITUTE FOR A WAIVER RESIDENTIAL SERVICE.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	staffing agency, home care agency, other PIHP network provider agency
Agency	Licensed Camp, Licensed Children's camp
Agency	Licensed Family Foster Home, Licensed Foster Family Group Home, Licensed Children's Therapeutic Group Home, Licensed Adult Foster Care,
Individual	Independent Nurse (RN or LPN)
Individual	Individual respite provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

staffing agency, home care agency, other PIHP network provider agency

Provider Qualifications

License *(specify):*

If respite is provided by an agency nurse, either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN, the RN or LPN must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the beneficiary being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Respite is typically provided by aides employed by the agency. Aides must meet criteria specified in the Michigan Behavioral Health Code Charts and Provider Qualifications: be at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary specific emergency procedures, and report on activities performed; in good standing with the law; able to perform basic first aid procedures; and is trained in the beneficiary's individuals plan of service, as applicable.

If the agency is providing respite rendered by a nurse, the nurse must be licensed by the State of Michigan as indicated above.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Camp, Licensed Children's camp

Provider Qualifications

License *(specify):*

Children's Camps: MCL 722.111, MCL 330.1153, Act 116 of 1973, Act 218 of 1978 as amended, Administrative Rule 400.11101-.11413
Adult's Camps: MCL 400.703, Act 218 of 1979 as amended, Administrative Rule 400.11101-.11413

Certificate *(specify):*

N/A

Other Standard *(specify):*

The camp must assure its employees are knowledgeable in the unique abilities, preferences and needs of the beneficiary.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Licensing and Regulatory Affairs

Frequency of Verification:

Initially and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Family Foster Home, Licensed Foster Family Group Home, Licensed Children's Therapeutic Group Home, Licensed Adult Foster Care,

Provider Qualifications

License *(specify):*

Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.9506 and R400.1401-.15411 and R400.1901-1906, MCL 722.115-118(a)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Licensing and Regulatory Affairs

Frequency of Verification:

Initially and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Nurse (RN or LPN)

Provider Qualifications

License *(specify):*

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

Other Standard *(specify):*

Nurses may provide respite only in situations where the beneficiary's medical needs are such that a trained respite aide cannot care for the beneficiary during times where the unpaid caregiver is requesting respite.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual respite provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aide must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03030 career planning

Category 3:

03 Supported Employment

Sub-Category 3:

03021 ongoing supported employment, individual

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Supported Employment services are services that are provided in a variety of community settings for the purposes of supporting individuals in obtaining and sustaining individual competitive integrated employment (CIE). CIE is individual employment that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Supported employment services support achieving full or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with co-workers without disabilities. Supported employment services promote self-direction, are customized, and aimed at meeting a beneficiary's personal and career goals and outcomes identified in the individualized person-centered service plan. Services may be provided continuously, intermittently, on behalf of, and encourage fading to promote community inclusion and competitive integrated employment.

Supported employment services include the following categories:
o Individual supported employment services are individualized. Services include:
o job related discovery
o person-centered employment/career planning
o job placement/job development, negotiation with prospective employers
o job analysis
o customized employment discovery and job carving, training and systematic instruction
o job coaching and systematic instruction
o benefits management, financial literacy, asset development and career advancement services career planning that supports an individual to make informed choices about individual competitive employment or self-employment. The outcome of this service is sustained individual competitive integrated employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals as outlined in the individual's person-centered service plan.
o training and planning
o transportation
o other workplace support services including services not specifically related to job skill training that enable the beneficiary to attain a job in a competitive integrated community setting of his/her choice

Self-employment refers to a beneficiary-run, IRS recognized self-employment business and nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings. Services include:
o vocational/job-related discovery or assessment
o person-centered employment planning
o benefits management, financial literacy, asset development and career advancement services
o relative business planning services

Supported/integrated employment service component(s) needed for each beneficiary are documented and coordinated. They are non-duplicative of those services otherwise available to an eligible person through a Vocational Rehabilitation program funded under the Workforce Innovation and Opportunity Act or the IDEA (20 U.S.C. 1401 et seq.). DOCUMENTATION TO ASSURE COMPLIANCE WILL BE IS MAINTAINED IN THE FILE OF EACH BENEFICIARY RECEIVING THIS SERVICE.

SKILL BUILDING ASSISTANCE IS NOT AVAILABLE UNDER A PROGRAM FUNDED UNDER SECTION 110 OF THE REHABILITATION ACT OF 1973 OR THE IDEA (20 U.S.C. 1401 ET SEQ.). DOCUMENTATION TO ASSURE COMPLIANCE WILL BE IS MAINTAINED IN THE FILE OF EACH BENEFICIARY RECEIVING THIS SERVICE.

If a beneficiary has a need for transportation to participate, maintain, or access the supported employment services, the same provider may be reimbursed for providing this transportation, only after it is determined that it is not otherwise available (e.g. volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid Provider Manual non-emergency medical transportation policy.

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

FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:
o Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program,
o Payments that are passed through to users of supported employment programs; or
o Payments for vocational training that is not directly related to a beneficiary's supported employment program.

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

☑ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☑ **Remote/via Telehealth**

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	employment specialist
Individual	job coach

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT

Provider Category:

Individual

Provider Type:

employment specialist

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual has completed specialized training; is able to perform basic first aid procedures, is trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary specific emergency procedures, and to report on employment related activities performed; and in good standing with the law. A job specialist must meet provider qualifications for an aide. EMPLOYMENT SPECIALIST MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT

Provider Category:

Individual

Provider Type:

job coach

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

A job coach must be trained in assisting a beneficiary with work-related activities in the beneficiary's workplace. A job coach must also meet provider qualifications for an aide. JOB COACH MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

In order to promote best practices, supported employment services staff must complete specialized employment training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Enhanced Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are NOT AVAILABLE UNDER THE STATE PLAN coverage or through other insurances. All enhanced medical equipment and supplies must be specified in the individual plan of service, and must enable the beneficiary to increase abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.

The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription. An order is valid one year from the date it was signed. This coverage includes:

- Items necessary for life support;
- Ancillary supplies and equipment necessary for proper functioning of such items;
- Durable and non-durable medical equipment not available under the Medicaid State Plan.

Generators may be covered for a beneficiary who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life- sustaining equipment.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

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

Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary are excluded from coverage.

- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

Coverage excludes furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home; items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs); and educational supplies that are required to be provided by the school as specified in the beneficiary's Individualized Education Plan. Eyeglasses, hearing aids, and dentures are not covered.

The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers that participate with that program.
MEDICAL EQUIPMENT AND SUPPLIES THAT CAN BE COVERED UNDER THE STATE PLAN SHOULD BE FURNISHED AS SERVICES REQUIRED UNDER Early AND PERIODIC SCREENING DIAGNOSTIC AND TREATMENT(EPSDT) TO WAIVER PARTICIPANTS UNDER AGE 21.

The size of a generator is limited to the wattage required to provide power to essential life-sustaining equipment.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Durable Medical Equipment and Supplies Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Durable Medical Equipment and Supplies Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The durable medical equipment and supplies (DMES) provider must meet any requirements by private insurance, Medicare or Medicaid as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP is responsible for verifying provider qualifications.

Frequency of Verification:

prior to contracting with the DMES provider for the item.

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:

Enhanced Pharmacy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

The services under the Enhanced Pharmacy are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

FFP cannot be used to pay for co-pays for other prescription plans the beneficiary may have.

Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	retailers

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Enhanced Pharmacy

Provider Category:

Agency

Provider Type:

retailers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Retailers must sell the enhanced pharmacy items. Beneficiaries may freely select the provider based on location or other factors.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP verifies prior to purchase that the retailer sells the item.

Frequency of Verification:

prior to purchase

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:

VEHICLE MODIFICATION

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:**

Service Definition *(Scope):*

VEHICLE MODIFICATIONS INCLUDE ADAPTATIONS OR ALTERATIONS TO AN AUTOMOBILE OR VAN THAT IS THE BENEFICIARY'S PRIMARY MEANS OF TRANSPORTATION IN ORDER TO ACCOMMODATE THE SPECIAL AND MEDICAL NEEDS OF THE BENEFICIARY. THESE ADAPTATIONS MUST BE SPECIFIED IN THE INDIVIDUAL PLAN OF SERVICE AND ENABLE THE BENEFICIARY TO INTEGRATE MORE FULLY INTO THE COMMUNITY AND TO ENSURE THE HEALTH, WELFARE AND SAFETY OF THE BENEFICIARY. THE INDIVIDUAL PLAN OF SERVICE MUST DOCUMENT THAT, AS A RESULT OF THE TREATMENT AND ITS ASSOCIATED EQUIPMENT OR ADAPTATION, INSTITUTIONALIZATION OF THE BENEFICIARY WILL BE PREVENTED. ALL ITEMS MUST BE ORDERED BY A PHYSICIAN ON A PRESCRIPTION AS DEFINED WITHIN THE MEDICAID PROVIDER MANUAL. AN ORDER IS VALID FOR ONE YEAR FROM THE DATE IT WAS SIGNED.

COVERAGE INCLUDES:
- ADAPTATIONS TO VEHICLES

ASSESSMENTS BY AN APPROPRIATE HEALTH CARE PROFESSIONAL, SPECIALIZED TRAINING NEEDED IN CONJUNCTION WITH THE USE OF THE ADAPTATIONS AND ALTERATIONS WILL BE CONSIDERED AS PART OF THE COST OF THE SERVICES.

COVERAGE EXCLUDES:
- THE PURCHASE OR LEASE OF A VEHICLE;
- ADAPTATIONS OR IMPROVEMENTS TO THE VEHICLE THAT ARE NOT OF DIRECT MEDICAL OR REMEDIAL BENEFIT TO THE BENEFICIARY;
- REGULARLY SCHEDULED UPKEEP AND MAINTENANCE OF A VEHICLE EXCEPT UPKEEP AND MAINTENANCE OF THE MODIFICATION(S).

COVERED ITEMS MUST MEET APPLICABLE STANDARDS OF MANUFACTURE, DESIGN, AND INSTALLATION. THERE MUST BE DOCUMENTATION THAT THE BEST VALUE IN WARRANTY COVERAGE WAS OBTAINED FOR THE ITEM AT THE TIME OF PURCHASE. IN ORDER TO COVER REPAIRS OF VEHICLE MODIFICATIONS, THERE MUST BE DOCUMENTATION IN THE INDIVIDUAL PLAN OF SERVICES THAT THE ALTERATIONS CONTINUE TO BE MEDICALLY NECESSARY. ALL APPLICABLE WARRANTY AND INSURANCE COVERAGES MUST BE SOUGHT AND DENIED BEFORE PAYING FOR REPAIRS. THE PIHP MUST DOCUMENT THAT THE REPAIR IS THE MOST COST-EFFECTIVE SOLUTION WHEN COMPARED WITH

REPLACEMENT OR PURCHASE OF A NEW ITEM. IF THE EQUIPMENT REQUIRES REPAIRS DUE TO MISUSE OR ABUSE, THE PIHP MUST PROVIDE EVIDENCE OF TRAINING IN THE USE OF THE EQUIPMENT TO PREVENT FUTURE INCIDENTS.

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

THE VEHICLE THAT IS ADAPTED MAY BE OWNED BY THE BENEFICIARY, A FAMILY MEMBER WITH WHOM THE BENEFICIARY LIVES OR HAS CONSISTENT AND ON-GOING CONTACT, OR A NON-RELATIVE WHO PROVIDES PRIMARY LONG-TERM SUPPORT TO THE BENEFICIARY AND IS NOT A PAID PROVIDER OF SUCH SERVICES.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	DURABLE MEDICAL EQUIPMENT AND SUPPLIES PROVIDER

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: VEHICLE MODIFICATION

Provider Category:

Agency

Provider Type:

DURABLE MEDICAL EQUIPMENT AND SUPPLIES PROVIDER

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

THE DURABLE MEDICAL EQUIPMENT AND SUPPLIES (DMES) PROVIDER MUST MEET ANY REQUIREMENTS BY PRIVATE INSURANCE, MEDICARE OR MEDICAID AS APPROPRIATE.

Verification of Provider Qualifications

Entity Responsible for Verification:

THE PIHP IS RESPONSIBLE FOR VERIFYING PROVIDER QUALIFICATIONS.

Frequency of Verification:

PRIOR TO CONTRACTING WITH THE DMES PROVIDER FOR THE ITEM.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Financial Management Services (FMS) is defined as services that assist the beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The FMS helps the beneficiary manage and distribute funds contained in the individual budget. Financial Management Services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring beneficiary-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The FMS may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include assisting with how to find providers, verification of provider qualifications (including reference and background checks) and assisting the beneficiary to understand billing and documentation requirements.

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

Financial Management Services are available only to beneficiaries choosing to self-direct.

Financial Management Services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or

when they are acting in a manner that is in conflict with the interests of the participant beneficiary.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Financial Management Services

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services

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 FMS is responsible for administering.
3. Demonstrated ability to manage budgets and perform all functions of the financial management service including all activities related to employment taxation, worker's compensation and state, local and federal regulations.
4. Financial Management Services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a FMS.
5. Neither providers of other covered services to the beneficiary, the family or guardians of the beneficiary may provide financial management services to the beneficiary.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP is responsible for assuring the provider is credentialed.

Frequency of Verification:

Prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Service Definition *(Scope):*

The purpose of the Goods and Services is to promote individual control over and flexible use of the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and Services can be services, equipment or supplies not otherwise provided through either the HSW, the State Plan or 1915 (i)SPA that address an identified need through the person-centered planning process. Each item or service specified in the IPOS must identify the beneficiary has a need and does not have the funds to purchase the good or service and the good or service is not available through another source.

Goods and Services must:

1. Increase independence, facilitate productivity, or promote, improve or maintain community inclusion and/or
2. Decrease the need for other Medicaid services and,
3. Be provided to, or directed exclusively toward, the benefit of the beneficiary,
4. Be identified through the person-centered planning process, is documented in the IPOS and meets the Goods and Services medical necessity criteria which identifies the need and demonstrates how the good or service will increase independence, productivity and community inclusion and
5. Be provided through a self-directed arrangement purchased through an individual budget.

A goods and services item can include the purchase of a warranty may be included when it is available for the item and is financially reasonable. A good may also include the purchase of adaptive clothing. Adaptive clothing is specifically designed to accommodate the needs of beneficiaries who require specialized garments. These specialized garments aim to enhance comfort, dignity, promote independence and ease the burden of dressing.

COVERAGE OF THIS SERVICE IS LIMITED TO WAIVERS THAT INCORPORATE THE BUDGET AUTHORITY PARTICIPANT DIRECTION OPPORTUNITY.

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

Goods and services have a limit of $2000 per year.

However, this coverage may not be used for the following:

1. To acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle,
2. Services covered by third parties or services that are the responsibility of a non-Medicaid program/service,
3. Services already covered through Medicaid plan, EPSDT and/or 1915 (i)SPA,
4. Health related services, equipment and supplies,
5. Room and board (including rent and mortgage payments),
6. Vacation expenses (travel, lodging costs, etc.) for the beneficiary and any paid staff who accompany the beneficiary on vacation.
7. Academic tutoring or other services covered under the Rehabilitation Act or IDEA
8. Internet, cell phones, utilities and telephone purchase or costs
9. Any purchase that does not meet HCBS settings requirements
10. Service animals or cost of pet care
11. Expenses and/or costs of meals incurred
12. Items or services if the purchase, as determined by PIHP:

a. leads to significant monetary gain for a beneficiary's support person(s).
b. provides the support person(s) with significant influence over the beneficiary; and/or
c. constitutes a conflict of interest. As used herein, the term "support person" includes an individual's spouse, children, parents, guardians, any person engaging in sexual activity with the individual, partners residing with the individual, and/or any person who provides paid services.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

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	goods and services provider

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:

goods and services provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Provider must be reputable and able to provide the good or service necessary.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS verifies provider qualifications. When the beneficiary chooses to purchase the good or service from a reputable provider through his or her budget authority under an arrangement supporting self-determination.

Frequency of Verification:

prior to purchasing or contracting to obtain the good or service

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:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Living Supports (CLS) facilitate a beneficiary's independence, productivity, and promote community inclusion and participation. The supports can be provided in the HSW beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.)

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973, or the waiver or State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite).

Coverage for Community Living Supports includes:

- STAFF ASSISTANCE, SUPPORT AND /OR TRAINING WITH ACTIVITIES SUCH AS:
- Meal preparation;
- Laundry;
- Routine, seasonal, and heavy household care and maintenance;
- Activities of Daily Living (ADLs), such as bathing, eating, dressing, personal hygiene;
- Shopping for food and other necessities of daily living.

In addition. CLS Coverage includes:
- Assisting, supporting and/or training the beneficiary with:
- Money management;
- Non-medical care (not requiring nurse or physician intervention);
- Socialization and relationship building;
- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence;
- Leisure choice and participation in regular community activities;
- Attendance at medical appointments; and
- Acquiring OR PROCURING PRODUCTS, RESOURCES AND ACCOMMODATIONS other than those listed under shopping AND NON-MEDICAL SERVICES
- Reminding, observing, and/or monitoring of medication administration.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed the MDHHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or filling out and submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs based on the findings of the MDHHS assessment. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.
THE CASE MANAGER WILL ASSIST THE BENEFICIARY IN SECURING CLS SERVICES BY PROVIDING A LIST OF CLS PROVIDERS AND OTHER HIRING RESOURCES, INCLUDING EDUCATION AND INFORMATION ON UTILIZING A SELF-DIRECTED ARRANGEMENT AND OPPORTUNITIES TO DIRECT HIRE STAFF THROUGH THIS METHOD. THIS WILL INCLUDE REFERRALS TO CLS PROVIDERS AS APPROPRIATE ALONG WITH MONITORING PROGRESS TO ENSURE ACCESS AND DELIVERY OF THE CLS SERVICE IS IMPLEMENTED AS IDENTIFIED IN THE IPOS.

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

The costs associated with room and board are excluded from CLS. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	licensed children's foster care, licensed adult foster care
Agency	home care agency, staffing agency, or other PIHP/CMHSP/other subcontractor or network provider agency
Individual	personal assistant, CLS aide

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:

licensed children's foster care, licensed adult foster care

Provider Qualifications

License *(specify):*

Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.14601, R400.15101-.15411, R400.2231-.2246, R400.1151-.1153, R400.1901-1906 and R400.2101-2475, MCL 722.115-118(a)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Licensing and Regulatory Affairs

Frequency of Verification:

Initially and every three years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Agency

Provider Type:

home care agency, staffing agency, or other PIHP/CMHSP/other subcontractor or network provider agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the beneficiary being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Supports

Provider Category:

Individual

Provider Type:

personal assistant, CLS aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS. AIDES MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental 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:**

Service Definition *(Scope):*

Physical adaptations to the home required by the beneficiary's individual plan of services (IPOS) that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable the beneficiary to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization.

Adaptations may include:

- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and
- environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers

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

All modifications must be ordered on a prescription as defined in the General Information Section of Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. An order is valid for one year from the date it was signed.

There must be documented evidence that the item is the most cost-effective and reasonable alternative to meet the beneficiary'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.

Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the plan as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.

Environmental modifications that are 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 beneficiary's home.

The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that 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. In the event that the contract is terminated prior to the completion of the work, HSW funds may not be used to pay for any additional costs resulting from the termination of the contract.

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

The environmental modification 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 beneficiary, with the direct assistance by the PIHP 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. A record of efforts to apply for alternative funding sources must be documented in the beneficiary's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP 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:

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental modifications that are essential to the implementation of the IPOS. Examples of exclusions include, but are not
limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

The HSW does not cover general construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver. If a beneficiary or his/her family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. HSW 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 HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need.

The infrastructure of the home involved in the funded modifications (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes.

ENVIRONMENTAL MODIFICATIONS 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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Licensed Building Contractor

Provider Qualifications

License *(specify):*

MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP is responsible for verifying provider qualifications

Frequency of Verification:

Prior to provision of service

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:

Family Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Training and counseling services for the families of beneficiaries served on this waiver. For purposes of this service, "family" is defined as the persons who live with AND PROVIDE UNCOMPENSATED CARE AND SUPPORT TO THE BENEFICIARY DIRECTLY RELATED TO THEIR ROLE IN SUPPORTING THE BENEFICIARY IN AREAS SPECIFIED IN THE IPOS.

Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the beneficiary at home. All family training must be included in the beneficiary's written plan of service.

FFP IS AVAILABLE FOR THE COSTS OF REGISTRATION AND TRAINING FEES ASSOCIATED WITH FORMAL INSTRUCTION IN AREAS RELEVANT TO PARTICIPANT NEEDS IDENTIFIED IN THE SERVICE PLAN.

The services under the Family Training are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Not included are individuals who are employed to provide waiver services for the beneficiary.

FFP IS NOT AVAILABLE FOR THE COSTS OF TRAVEL, MEALS, AND OVERNIGHT LODGING TO ATTEND A TRAINING EVENT OR CONFERENCE.

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

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

☑ **Provider managed**

☑ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse)
Agency	CMHSPs/other subcontractor, home care agencies, clinic service agency providers, outpatient clinics

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

Service providers for Family Training must be either a licensed psychologist, master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Agency

Provider Type:

CMHSPs/other subcontractor, home care agencies, clinic service agency providers, outpatient clinics

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

The service provider must be either a licensed psychologist, Master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Family Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) and respite staff by clinical professional working within the scope of their practice. Professional staff work with CLS and respite staff to implement the beneficiary's IPOS, with focus on all behavioral health services designed to assist the beneficiary in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The activities of the professional staff ensure the appropriateness of services delivered by CLS and respite staff and continuity of care. The service provider is selected on the basis of his/her competency in the aspect of the IPOS on which training is conducted.

The services under the Non-Family Training are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Clinical professional (e.g., psychologist, social worker, occupational therapist, physical therapist, speech therapist, nurse)
Agency	CMHSPs; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Family Training

Provider Category:

Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

Service providers Non-Family training must be either a licensed psychologist, master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Family Training

Provider Category:

Agency

Provider Type:

CMHSPs; agencies contracted to CMHSPs (e.g., home care agencies, clinical service agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Other Standard *(specify):*

The hands-on service provider must be either a licensed psychologist, master's level social worker, or QIDP. The service provider is selected on the basis of his/her competency in the aspect of the service plan on which they are conducting training.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Overnight Health and Safety Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Overnight Health and Safety Support is defined as the need for someone to be present to prevent, oversee, manage, direct, or respond to a beneficiary's disruptive, risky, or harmful behaviors, during the overnight hours. Overnight Health and Safety Support is indicated for a person who is non-self-directing, confused, has a cognitive impairment or whose physical functioning is such that they are unable to respond appropriately in an emergency. It is further indicated for beneficiaries who have inconsistency in, or an inability to, regulate sleep patterns.

For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period. The need for Overnight Health and Safety Support must be reviewed and established through the person-centered planning process with the specific reasons for this service and what support activities will be provided.

Overnight Health and Safety Support may be appropriate when:

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

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

Payments for Overnight Health and Safety Support may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

The Overnight Health and Safety Support service cannot be provided in a licensed residential setting.

If the beneficiary receiving Overnight Health and Safety Support demonstrates the need for CLS or Respite, the IPOS must document coordination of services to assure no duplication of services provision with Overnight Health and Safety Support.

The following exceptions apply for Overnight Health and Safety Support:

- It does not include friendly visiting or other social activities.
- It is not available for medical needs beyond provider qualification requirements (aide level staff) for this service.
- Is not available to prevent or control anti-social or aggressive recipient behavior.
- Is not available for a person without a physical, cognitive, or memory impairment who has anxiety about being alone at

night
- Is not an alternative to inpatient psychiatric treatment and is not available to prevent potential suicide or other life-threatening self-harm behaviors.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Aide
Agency	Home care agency, staff agency and other PIHP/CMHSP or contracted providers

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies provider qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

Prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home care agency, staff agency and other PIHP/CMHSP or contracted providers

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the beneficiary being served.
Overnight Health and Safety Support is provided by aide level staff. Aides must meet the following criteria:
At least 18 years of age; be able to practice universal precaution and infection control techniques; in good standing with the law ; be trained in recipient rights; able to perform basic first aid as evidenced by completion of first aid training course, or other method determined by the PIHP to demonstrate competence; able to perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence; has received training in the beneficiary's IPOS.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to contracting and every three years

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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) is an electronic device that enables certain beneficiaries at high risk of institutionalization to secure help in an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year.

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

PERS services are limited to those beneficiaries who live alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day, and have no regular caregiver support/service provider for extended periods of time, and who would otherwise require extensive routine supervision and guidance.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 beneficiaries 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 PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the provider through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to contracting and every three years

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Private Duty Nursing (PDN) services consist of skilled nursing interventions to meet the beneficiary's health needs that are directly related to his or her developmental disability. PDN includes the provision of nursing assessment, treatments 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 written health care plan which is part of the beneficiary's IPOS.

PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The beneficiary receiving PDN must also require at least one of the following habilitative services through the waiver.

- Community living supports
- Out-of-home non-vocational habilitation
- Supported Employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.

Medical Criteria I - The beneficiary 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) due to a substantiated medical condition directly related to the developmental disability.

Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical 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 beneficiary in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

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

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse.

Skilled nursing care includes, but is not limited to:
- performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
- managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi- PAP) that is required by the beneficiary four or more hours per day;
- deep oral (past the tonsils) or tracheostomy suctioning;
- 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);
- nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
- total parenteral nutrition delivered via a central line and care of the central line;
- continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for 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;
- 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.

Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:
- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.

High Category: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.

Medium Category: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.

Low Category: Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN, i.e., the number of hours, that can be authorized for a beneficiary is determined through the person-centered planning process to address the beneficiary's unique needs and circumstances. Factors to be considered should

include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances, e.g., the availability of natural supports; and other resources for daily care, e.g., private health insurance, trusts, bequests. Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, beneficiary who has Low Category PDN needs would require eight or fewer hours per day, beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing assessments, treatments, observation, judgment and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

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

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

The services under the Private Duty Nursing are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

PDN services are provided to beneficiaries age 21 and older up to a maximum of 16 hours per day. Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

Exceptions to the hours-per-day limit: An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:
-current medical necessity for the exception, and
-additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his or her condition.

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

1. A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:
•A temporary increase in the intensity of required assessments, judgments, and interventions.
•A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration

of the beneficiary's increased medical needs for a maximum of six months.

or

2. The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
•In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
•The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
•The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

Definitions: "Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care. "Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

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

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

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	private duty nursing agency, home care agency
Individual	Private Duty Nurse (RN or LPN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

private duty nursing agency, home care agency

Provider Qualifications

License *(specify):*

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

N/A

Other Standard *(specify):*

The agency should assure that personnel providing this HSW service are knowledgeable in the unique abilities, preferences and needs of the beneficiary receiving the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP verifies agency qualifications. The agency is responsible for assuring its employees meet provider qualifications for the HSW service being delivered as specified in the Behavioral Health Code Charts and Provider Qualifications. If the beneficiary chooses to hire the agency through his or her budget authority under a self- determination arrangement, the PIHP may delegate the responsibility for verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Individual

Provider Type:

Private Duty Nurse (RN or LPN)

Provider Qualifications

License *(specify):*

This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211

Certificate *(specify):*

N/A

Other Standard *(specify):*

It is the LPN's responsibility to secure the services of an RN to supervise his or her work.

Verification of Provider Qualifications

Entity Responsible for Verification:

The PIHP contracting with the nurse must verify provider qualifications. An LPN must provide the supervising RN's information to the PIHP for verification of provider qualifications as well. If the beneficiary chooses to hire the provider through his or her budget authority under a self-determination arrangement, the PIHP may delegate the responsibility for

verifying provider qualifications to the beneficiary or his/her agent.

Frequency of Verification:

prior to delivery of services and every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

SMALL GROUP SUPPORTED EMPLOYMENT IS NOT COMPETITIVE INTEGRATED EMPLOYMENT. SERVICES INSTEAD PROVIDE TRAINING ACTIVITIES PROVIDED IN TYPICAL BUSINESS, INDUSTRY AND COMMUNITY SETTINGS FOR GROUPS OF TWO TO SIX WORKERS WITH DISABILITIES PAYING AT LEAST MINIMUM WAGE. THE PURPOSE OF FUNDING FOR THIS SERVICE IS TO SUPPORT SUSTAINED PAID EMPLOYMENT AND WORK EXPERIENCE THAT LEADS TO INDIVIDUAL COMPETITIVE INTEGRATED EMPLOYMENT. EXAMPLES INCLUDE MOBILE CREWS, ENCLAVES, AND OTHER BUSINESS-BASED WORKGROUPS EMPLOYING SMALL GROUPS OF WORKERS WITH DISABILITIES. SUPPORTED EMPLOYMENT SERVICES FOR SMALL GROUPS MUST PROMOTE INTEGRATION INTO THE WORKPLACE AND INTERACTION BETWEEN WORKERS WITH DISABILITIES AND PEOPLE WITHOUT DISABILITIES IN THOSE WORKPLACES. SERVICES INCLUDE:

O JOB ANALYSIS
O TRAINING AND SYSTEMATIC INSTRUCTION
O TRAINING AND PLANNING
O TRANSPORTATION
O OTHER WORKPLACE SUPPORT SERVICES MAY INCLUDE SERVICES NOT SPECIFICALLY RELATED TO

JOB SKILL TRAINING THAT ENABLE THE WAIVER BENEFICIARY TO BE SUCCESSFUL IN INTEGRATING INTO THE WORKPLACE.

SUPPORTED/INTEGRATED EMPLOYMENT SERVICE COMPONENT(S) NEEDED FOR EACH BENEFICIARY ARE DOCUMENTED AND COORDINATED. THEY ARE NON-DUPLICATIVE OF THOSE SERVICES OTHERWISE AVAILABLE TO AN ELIGIBLE PERSON THROUGH A VOCATIONAL REHABILITATION PROGRAM FUNDED UNDER THE WORKFORCE INNOVATION AND OPPORTUNITY ACT OR THE IDEA (20 U.S.C. 1401 ET SEQ.). DOCUMENTATION TO ASSURE COMPLIANCE WILL BE IS MAINTAINED IN THE FILE OF EACH BENEFICIARY RECEIVING THIS SERVICE.

SKILL BUILDING ASSISTANCE IS NOT AVAILABLE UNDER A PROGRAM FUNDED UNDER SECTION 110 OF THE REHABILITATION ACT OF 1973 OR THE IDEA (20 U.S.C. 1401 ET SEQ.). DOCUMENTATION TO ASSURE COMPLIANCE WILL BE IS MAINTAINED IN THE FILE OF EACH BENEFICIARY RECEIVING THIS SERVICE.

IF A BENEFICIARY HAS A NEED FOR TRANSPORTATION TO PARTICIPATE, MAINTAIN, OR ACCESS THE SUPPORTED EMPLOYMENT SERVICES, THE SAME PROVIDER MAY BE REIMBURSED FOR PROVIDING THIS TRANSPORTATION, ONLY AFTER IT IS DETERMINED THAT IT IS NOT OTHERWISE AVAILABLE (E.G. VOLUNTEER, FAMILY MEMBER) AND IS THE LEAST EXPENSIVE AVAILABLE MEANS SUITABLE TO THE BENEFICIARY'S NEED, IN ACCORDANCE WITH THE MEDICAID PROVIDER MANUAL NON-EMERGENCY MEDICAL TRANSPORTATION POLICY.

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

FFP MAY NOT BE CLAIMED FOR INCENTIVE PAYMENTS, SUBSIDIES, OR UNRELATED VOCATIONAL TRAINING EXPENSES SUCH AS:
O INCENTIVE PAYMENTS MADE TO AN EMPLOYER TO ENCOURAGE OR SUBSIDIZE THE EMPLOYER'S PARTICIPATION IN A SUPPORTED EMPLOYMENT PROGRAM
O PAYMENTS THAT ARE PASSED THROUGH TO USERS OF SUPPORTED EMPLOYMENT PROGRAMS; OR
O PAYMENTS FOR VOCATIONAL TRAINING THAT IS NOT DIRECTLY RELATED TO A BENEFICIARY'S SUPPORTED EMPLOYMENT PROGRAM.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	EMPLOYMENT SPECIALIST
Individual	JOB COACH

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT

Provider Category:

Individual

Provider Type:

EMPLOYMENT SPECIALIST

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Individual has completed specialized training; is able to perform basic first aid procedures, is trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary specific emergency procedures, and to report on employment related activities performed; and in good standing with the law. A job specialist must meet provider qualifications for an aide. EMPLOYMENT SPECIALIST MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

Verification of Provider Qualifications

Entity Responsible for Verification:

THE PIHP VERIFIES PROVIDER QUALIFICATIONS. IF THE BENEFICIARY CHOOSES TO HIRE THE PROVIDER THROUGH HIS OR HER BUDGET AUTHORITY UNDER A SELF-DETERMINATION ARRANGEMENT, THE PIHP MAY DELEGATE THE RESPONSIBILITY FOR VERIFYING PROVIDER QUALIFICATIONS TO THE BENEFICIARY OR HIS/HER AGENT.

Frequency of Verification:

PRIOR TO DELIVERY OF SERVICES AND EVERY THREE YEARS THEREAFTER

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT

Provider Category:

Individual

Provider Type:

JOB COACH

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

A job coach must be trained in assisting a beneficiary with work-related activities in the beneficiary's workplace. A job coach must also meet provider qualifications for an aide. In order to promote best practices, supported employment services staff must complete specialized employment training. JOB COACH MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

Verification of Provider Qualifications

Entity Responsible for Verification:

THE PIHP VERIFIES PROVIDER QUALIFICATIONS. IF THE BENEFICIARY CHOOSES TO HIRE THE PROVIDER THROUGH HIS OR HER BUDGET AUTHORITY UNDER A SELF-DETERMINATION ARRANGEMENT, THE PIHP MAY DELEGATE THE RESPONSIBILITY FOR VERIFYING PROVIDER QUALIFICATIONS TO THE BENEFICIARY OR HIS/HER AGENT.

Frequency of Verification:

PRIOR TO DELIVERY OF SERVICES AND EVERY THREE YEARS THEREAFTER

Appendix C: Participant Services

C-1: 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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid state plan service under section 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.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The PIHPs or their contracting agency are responsible for conducting case management functions and for the coordination of waiver services on behalf of waiver beneficiaries. Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP): A QIDP is an individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, or a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.

ALL CASE MANAGERS MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Out-of-Home Non-Vocational Habilitation
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT
Community Living Supports
Family Training

Service
Non-Family Training

1. Will any in-person visits be required?

- (•) **Yes.**
- ( ) **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

- ☑ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

MDHHS TELEMEDICINE POLICY POST-COVID-19 PUBLIC HEALTH EMERGENCY SPECIFIES FACE TO FACE DEFINAITION AS; EITHER AN IN-PERSON VISIT, OR A VISIT PERFORMED VIA SIMULTANEOUS AUDIO/VISUAL TECHNOLOGY. THE DELIVERY OF COMMUNITY LIVING SUPPORTS SERVICES MUST BE PROVIDED IN-PERSON WHEN THESE SERVICES REQUIRE PROMPTING, GUIDING AND/OR TRAINING. IF A BENEFICIARY REQUIRES PHYSICAL ASSISTANCE, THEN THE DELIVERY OF SERVICE IS EXPECTED TO BE IN PERSON. THE DELIVERY OF SUPPORTED EMPLOYMENT - INDIVIDUAL SUPPORTED EMPLOYMENT, CAN BE DELIVERED VIA SIMULTANEOUS AUDIO/VISUAL OR AUDIO ONLY DEPENDENT ON THE BENEFICARY NEED AS ESTABLISHED THROUGH THE PCP PROCESS AND IDENTIFIED IN THE IPOS. THE DELIVERY OF FAMILY TRAINING MUST BE PROVIDED FACE-TO FACE WITH THOSE IDENTIFIED AS FAMILY. THE DELIVERY OF NON-FAMILY TRAINING MUST BE FACE-TO-FACE WITH COMMUNITY LIVING SUPPORT AND RESPITE PROVIDERS. THE DELIVERY OF OUT-OF-HOME NONVOCATIONAL SERVICES MUST BE PROVIDE FACE-TO-FACE IN A COMMUNITY SETTING, NOT IN A BENEFICIARY'S HOME.

MDHHS HAS ESTABLISHED POST-PHE TELEMEDICINE POLICIES MSA 20-09(https://www.michigan.gov/en/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-policy-bulletins-2021), MSA 21-24(https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-policy-bulletins-2022) AND MMP 23-10 (https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/2023-medicaid-policy-bulletins). MDHHS POLICY OUTLINES PRIVACY AND SECURITY MEASURES MUST BE IN PLACE TO ENSURE THE PRIVACY OF THE BENEFICIARY AND SECURITY OF ANY INFORMATION SHARED VIA TELEMEDICINE IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND ALL OTHER PRIVACY/SECURITY REGULATIONS THAT ARE APPLICABLE.

FURTHERMORE, TELEMEDICINE MUST ONLY BE UTILIZED WHEN THE BENEFICIARY'S GOALS FOR THE VISIT CAN BE ADEQUATELY ACCOMPLISHED, THERE EXISTS REASONABLE CERTAINTY OF THE BENEFICIARY'S ABILITY TO EFFECTIVELY UTILIZE THE TECHNOLOGY, AND THE BENEFICIARY'S COMFORT WITH THE NATURE OF THE VISIT IS ENSURED. TELEMEDICINE MUST BE USED AS APPROPRIATE REGARDING THE BEST INTERESTS/PREFERENCES OF THE BENEFICIARY AND NOT MERELY FOR PROVIDER EASE. A SECURED ELECTRONIC CHANNEL MUST INCLUDE AND SUPPORT ALL OF THE FOLLOWING FOR AUDIO AND AUDIO/ VISUAL ENCOUNTERS:
1. THE ELECTRONIC CHANNEL MUST BE SECURE, WITH PROVISIONS FOR PRIVACY AND SECURITY, INCLUDING ENCRYPTION, IN ACCORDANCE WITH HIPAA GUIDELINES. 2. A MECHANISM MUST BE IN PLACE TO AUTHENTICATE THE IDENTITY OF CORRESPONDENT(S) IN ELECTRONIC COMMUNICATION AND TO ENSURE THAT RECIPIENTS OF INFORMATION ARE AUTHORIZED TO RECEIVE IT. 3. THE PATIENT'S INFORMED CONSENT TO PARTICIPATE IN THE CONSULTATION MUST BE OBTAINED, INCLUDING DISCUSSING APPROPRIATE EXPECTATIONS, DISCLAIMERS AND SERVICE TERMS, AND ANY FEES THAT MAY BE IMPOSED. EXPECTATIONS FOR APPROPRIATE USE MUST BE SPECIFIED AS PART OF THE CONSENT PROCESS INCLUDING USE OF SPECIFIC WRITTEN GUIDELINES AND PROTOCOLS, AVOIDING EMERGENCY USE, HEIGHTENED CONSIDERATION OF USE FOR HIGHLY SENSITIVE MEDICAL TOPICS RELEVANT TO PRIVACY ISSUES. 4. THE NAME AND PATIENT IDENTIFICATION NUMBER IS CONTAINED IN THE BODY OF THE MESSAGE, WHEN APPLICABLE. 5. A STANDARD BLOCK OF TEXT IS CONTAINED IN THE PROVIDER'S RESPONSE THAT CONTAINS THE PHYSICIAN'S FULL NAME, CONTACT INFORMATION, AND REMINDERS ABOUT SECURITY AND THE IMPORTANCE OF ALTERNATIVE FORMS OF COMMUNICATION FOR EMERGENCIES, WHEN APPLICABLE. 6. THE MEDICAL RECORD OF THE TELEMEDICINE VISIT SHOULD INCLUDE, IF APPLICABLE, COPIES OF ALL PATIENT-RELATED ELECTRONIC COMMUNICATIONS, INCLUDING PATIENT-PHYSICIAN COMMUNICATION, PRESCRIPTIONS, LABORATORY AND TEST RESULTS, EVALUATIONS AND CONSULTATIONS, RECORDS OF PAST CARE, AND INSTRUCTIONS OBTAINED OR PRODUCED IN CONNECTION WITH THE UTILIZATION OF TELEMEDICINE TECHNOLOGIES. INFORMED CONSENTS OBTAINED IN CONNECTION WITH AN ENCOUNTER INVOLVING TELEMEDICINE

TECHNOLOGIES SHOULD ALSO BE FILED IN THE MEDICAL RECORD.

☑ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

THE PIHP/CMHSPS USE OF TELEMEDICINE SHOULD ENSURE AND PROMOTE COMMUNITY INTEGRATION AND PREVENT ISOLATION OF THE BENEFICIARY. EVIDENCE-BASED PRACTICE POLICIES MUST BE FOLLOWED AS APPROPRIATE FOR ALL SERVICES. FOR SERVICES WITHIN THE COMMUNITY, IN-PERSON INTERACTIONS MUST BE PRIORITIZED.

☑ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

USE OF COMMUNITY LIVING SUPPORTS VIA TELEHEALTH CAN BE THE METHOD OF SERVICE DELIVERY IF INTERVENTIONS REQUIRE VERBAL CUING OR DIRECTION AND NOT PHYSICAL (HANDS ON) PROMPTING, GUIDING AND/OR TRAINING. IF A BENEFICIARY REQUIRES PHYSICAL ASSISTANCE, THEN THE DELIVERY OF SERVICE IS EXPECTED TO BE IN PERSON.

☑ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

TELEMEDICINE MUST ONLY BE UTILIZED WHEN THE BENEFICIARY'S GOALS FOR THE VISIT CAN BE ADEQUATELY ACCOMPLISHED, THERE EXISTS REASONABLE CERTAINTY OF THE BENEFICIARY'S ABILITY TO EFFECTIVELY UTILIZE THE TECHNOLOGY, AND THE BENEFICIARY'S COMFORT WITH THE NATURE OF THE VISIT IS ENSURED. TELEMEDICINE MUST BE USED AS APPROPRIATE REGARDING THE BEST INTERESTS/PREFERENCES OF THE BENEFICIARY AND NOT MERELY FOR PROVIDER EASE. APPROPRIATE GUIDANCE MUST BE PROVIDED TO THE BENEFICIARY TO ENSURE THEY ARE PREPARED AND UNDERSTAND ALL STEPS TO EFFECTIVELY UTILIZE THE TECHNOLOGY PRIOR TO THE FIRST VISIT. BENEFICIARY CONSENT MUST BE OBTAINED PRIOR TO SERVICE PROVISION.

☑ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

TELEHEALTH VISITS SHOULD YIELD THE DESIRED OUTCOMES FOR THE BENEFICIARY AND ENSURE QUALITY. OUTCOMES SHOULD BE IMPROVING AND REMAIN CONSISTENT WITH IN-PERSON CARE AT A MINIMUM. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE SAFETY AND QUALITY OF SERVICES PROVIDED WITH TELEMEDICINE TECHNOLOGIES.

IF THE INDIVIDUAL (BENEFICIARY) IS NOT ABLE TO COMMUNICATE EFFECTIVELY OR INDEPENDENTLY THEY MUST BE PROVIDED APPROPRIATE ON-SITE SUPPORT FROM NATURAL SUPPORTS OR STAFF. THIS INCLUDES THE APPROPRIATE SUPPORT NECESSARY TO PARTICIPATE IN ASSESSMENTS, SERVICES, AND TREATMENT. THE CMHSP/PIHP MUST GUARANTEE THE INDIVIDUAL IS NOT BEING INFLUENCED OR PROMPTED BY OTHERS WHEN UTILIZING TELEMEDICINE. USE OF TELEMEDICINE SHOULD ENSURE AND PROMOTE COMMUNITY INTEGRATION AND PREVENT ISOLATION OF THE BENEFICIARY.

Appendix C: Participant Services

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

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal

history and/or background investigations of individuals who provide waiver services (select one):

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

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

(a)Criminal history/background investigations are completed for all direct care aide-level staff, all clinicians, and other employees providing waiver services in the PIHP provider network panels.

The PIHP or its contracted provider agency is responsible for completing the criminal history/background investigation by checking statewide databases and for providing documentation in the employees personnel file. Investigations must be of sufficient scope to conclude that the aide is in good standing with the law. Requirements for waiver service providers are set forth in the Behavioral Health Code Charts and Provider Qualifications. Additionally, for those HSW beneficiaries receiving services within Adult Foster Care Facilities, MCL 400.734b provides that all applicants for employment that include direct access to residents to whom the AFC provider has made a good faith employment offer shall, prior to reporting for said employment, have been found to have: 1) no relevant criminal history via a comprehensive criminal history check including running the individual's fingerprints through the automated fingerprint identification system database; and,

b) no substantiated findings of abuse, neglect, or misappropriation of property via checks of all relevant registries established pursuant to federal and state law and regulations by the relevant licensing or regulatory department.

(c) The MDHHS site reviews are the mechanisms for ensuring the background checks are completed through random sampling of records.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

MICHIGAN'S CENTRAL REGISTRY maintains an abuse registry for children only which tracks Children's Protective Services (CPS) cases that result in confirmed methamphetamine production, confirmed serious abuse or neglect, confirmed sexual abuse, or confirmed sexual exploitation will be classified as a central registry case in Michigan. In addition, select criminal convictions involving children will result in placement on central registry. THE PIHPS ARE REQUIRED TO UTILIZE THIS CENTRAL REGISTRY AS PART OF THEIR CREDENTIALING OF PROFESSIONAL (ALL CLINICAL AND DIRECT SERVICE PROVIDERS) STAFF WHO PROVIDE SERVICES TO CHILDREN. THIS IS A REQUIREMENT OF THEIR CONTRACT WITH MDHHS. DURING THE MDHHS SITE REVIEW PROCESS THIS WILL BE MONITORED TO ENSURE COMPLIANCE. At this time there is no adult registry screening that the state maintains.

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to 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; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

If a relative who is not the legally responsible individual, i.e., parent of minor child, spouse, or legal guardian, meets the provider qualifications, he or she may be paid for provision of that service FOLLOWING THE PARAMETERS OF ANY LIMITS SET WITHIN THE DEFINITION OF EACH SERVICE AND AS SPECIFIED IN THE IPOS. The services that may be provided by a relative are: out-of-home nonvocational habilitation, respite, supported employment, community living supports, overnight health and safety support, and private duty nursing. The HSW service descriptions include language that prohibits payment to legally responsible individuals. The PIHPs are responsible for assuring that all providers meet the provider qualifications as specified in the Medicaid Provider Manual Behavioral Health Code Charts and Provider Qualifications for HSW services. The supports coordinator or other provider selected by the beneficiary reviews service logs against planned hours, makes home visits and discusses service provision with the beneficiary and others involved in his/her IPOS to help evaluate congruence between planned and billed hours and the documentation of the types of services delivered as specified in the IPOS. PROVISION OF SERVICE MUST ADHERE TO APPLICABLE EMPLOYMENT LAW.

THE DETERMINATION OF WHETHER A RELATIVE MAY BE A PAID PROVIDER OF SERVICE WOULD BE MADE ON AN INDIVIDUAL BASIS THROUGH THE PERSON-CENTERED PLANNING PROCESS TO ASSESS WHETHER A CONFLICT OF INTEREST WOULD EXIST IF THE RELATIVE WAS A PAID STAFF PERSON. IF IT IS DETERMINED THAT A CONFLICT OF INTEREST DOES NOT EXIST A RELATIVE MAY BE HIRED BY A DIRECT SERVICE PROVIDER OR THROUGH A SELF-DIRECTED ARRANGEMENT IF THE BENEFICIARY HAS A SELF-DIRECTED BUDGET.

- **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:

PROVIDER NETWORK SERVICES CONTRACTOR IS RESPONSIBLE FOR MAINTAINING AND CONTINUALLY EVALUATING AN EFFECTIVE PROVIDER NETWORK ADEQUATE TO FULFILL THE OBLIGATIONS OF THIS CONTRACT. CONTRACTOR REMAINS THE ACCOUNTABLE PARTY FOR THE MEDICAID BENEFICIARIES IN ITS SERVICE AREA, REGARDLESS OF THE FUNCTIONS IT HAS DELEGATED TO ITS PROVIDER NETWORKS AS SPECIFIED IN 42 CFR 438.230. IN THIS REGARD AND IN COMPLIANCE WITH 42 CFR PARTS 438.414; 438.10(G)(2)(XI)(C)(D)(E) AND 457.1260, CONTRACTOR MUST: A. MAINTAIN A REGULAR MEANS OF COMMUNICATING AND PROVIDING INFORMATION ON CHANGES IN POLICIES AND PROCEDURES TO ITS PROVIDERS. THIS MAY INCLUDE GUIDELINES FOR ANSWERING WRITTEN CORRESPONDENCE TO PROVIDERS, OFFERING PROVIDER- DEDICATED PHONE LINES, AND A REGULAR PROVIDER NEWSLETTER. B. HAVE CLEARLY WRITTEN MECHANISMS TO ADDRESS PROVIDER GRIEVANCES AND COMPLAINTS, AND AN APPEAL SYSTEM TO RESOLVE DISPUTES. C. PROVIDE A COPY OF CONTRACTOR'S PRIOR AUTHORIZATION POLICIES TO THE PROVIDER WHEN THE PROVIDER JOINS CONTRACTOR'S PROVIDER NETWORK. CONTRACTOR MUST NOTIFY PROVIDERS OF ANY CHANGES TO PRIOR AUTHORIZATION POLICIES. D. PROVIDE A COPY OF CONTRACTOR'S GRIEVANCE, APPEAL AND FAIR HEARING PROCEDURES AND TIMEFRAMES TO THE PROVIDER WHEN THE PROVIDER JOINS CONTRACTOR'S PROVIDER NETWORK. CONTRACTOR MUST NOTIFY PROVIDERS OF ANY CHANGES TO THOSE PROCEDURES OR TIMEFRAMES. E. PROVIDE TO THE STATE, IN THE FORMAT SPECIFIED BY THE STATE, PROVIDER AGENCY INFORMATION PROFILES THAT CONTAIN A COMPLETE LISTING AND DESCRIPTION OF THE PROVIDER NETWORK AVAILABLE TO RECIPIENTS IN THE SERVICE AREA. F. ASSURE THAT SERVICES ARE ACCESSIBLE, TAKING INTO ACCOUNT TRAVEL TIME, AVAILABILITY OF PUBLIC TRANSPORTATION, AND OTHER FACTORS THAT MAY DETERMINE ACCESSIBILITY. G. ASSURE THAT NETWORK PROVIDERS DO NOT SEGREGATE BENEFICIARIES IN ANY WAY FROM OTHER INDIVIDUALS RECEIVING THEIR SERVICES.

NETWORK REQUIREMENTS A. CONTRACTOR MUST MAINTAIN A NETWORK OF QUALIFIED PROVIDERS IN SUFFICIENT NUMBERS, MIX, AND GEOGRAPHIC LOCATIONS THROUGHOUT THEIR RESPECTIVE SERVICE AREA FOR THE PROVISION OF ALL COVERED SERVICES. CONTRACTOR MAY ALSO UTILIZE QUALIFIED PROVIDERS FROM OUTSIDE CONTRACTOR'S SERVICE AREA FOR THE PROVISION OF COVERED SERVICES. B. CONTRACTOR MUST CONSIDER ANTICIPATED ENROLLMENT AND EXPECTED UTILIZATION OF SERVICES. C. CONTRACTOR MUST PROVIDE DOCUMENTATION ON WHICH THE STATE BASES ITS CERTIFICATION THAT PAGE 37 OF 148 CONTRACTOR COMPLIED WITH THE STATE'S REQUIREMENTS FOR AVAILABILITY AND ACCESSIBILITY OF SERVICES, INCLUDING THE ADEQUACY OF THE PROVIDER NETWORK AS REFERENCED IN 42 CFR PARTS 438.604(A)(5); 438.606; 438.207(B) AND 438.206. SUBMISSION OF DOCUMENTATION WILL TAKE PLACE AS SPECIFIED BY THE STATE BUT NO LESS FREQUENTLY THAN THE FOLLOWING: I. AT THE TIME CONTRACTOR ENTERS INTO A CONTRACT WITH THE STATE. II. ON AN ANNUAL BASIS. III. ANYTIME THERE HAS BEEN SIGNIFICANT CHANGE (AS DEFINED BY THE STATE) IN CONTRACTOR OPERATIONS THAT WOULD AFFECT ADEQUACY OF CAPACITY AND SERVICES, INCLUDING CHANGES IN SERVICES, BENEFITS, GEOGRAPHIC SERVICE AREA, COMPOSITION OF OR PAYMENTS TO ITS PROVIDER NETWORKS, OR AT THE ENROLLMENT OF A NEW POPULATION. D. CONTRACTOR MUST SUBMIT ANY OTHER DATA, DOCUMENTATION, OR INFORMATION RELATING TO THE PERFORMANCE OF THE ENTITY'S OBLIGATIONS AS REQUIRED BY THE STATE AS REFERENCED IN 42 CFR PARTS 438.604(B) AND 438.606. E. IN ACCORDANCE WITH 42 CFR 438.14, CONTRACTOR MUST DEMONSTRATE THAT THERE ARE SUFFICIENT INDIAN HEALTH CARE PROVIDERS (IHCP) PARTICIPATING IN THE PROVIDER NETWORK TO ENSURE TIMELY ACCESS TO SERVICES AVAILABLE UNDER THE CONTRACT FROM SUCH PROVIDERS FOR INDIAN BENEFICIARIES WHO ARE ELIGIBLE TO RECEIVE SERVICES. I. IF TIMELY ACCESS TO COVERED SERVICES CANNOT BE ENSURED DUE TO FEW OR NO IHCPS, CONTRACTOR MUST: 1) ALLOW INDIAN BENEFICIARIES TO ACCESS OUT-OF-STATE IHCPS; OR 2) SHOW GOOD CAUSE FOR DISENROLLMENT FROM BOTH CONTRACTOR AND THE STATE'S MANAGED CARE PROGRAM IN ACCORDANCE WITH 42 CFR § 438.56(C). II. CONTRACTOR MUST PERMIT INDIAN BENEFICIARIES TO OBTAIN SERVICES COVERED UNDER THE CONTRACT FROM OUT-OF- NETWORK IHCPS FROM WHOM THE BENEFICIARY IS OTHERWISE ELIGIBLE TO RECEIVE SUCH SERVICES. III. CONTRACTOR MUST PERMIT AN OUT-OF-NETWORK IHCP TO REFER AN INDIAN BENEFICIARY TO A NETWORK PROVIDER.

The Habilitation Supports Waiver operates concurrently with the State's §1115 managed care authority. The enrollment of providers is governed under the provisions of the MDHHS/PIHP contract, which were derived from 42 CFR §438.207. PIHPs are required to maintain a network of providers that is sufficient in number, mix, and geographic distribution to

meet the needs/assure services and supports provision consistent with the plans of services of their beneficiaries, and to include beneficiary-requested providers on their enrolled provider panels when they meet the PIHPs qualifications, cost, and reasonable accommodation parameters.

PIHP MUST PROVIDE DOCUMENTATION ON WHICH THE STATE BASES ITS CERTIFICATION THAT THE PIHP COMPLIED WITH THE STATE'S REQUIREMENTS FOR AVAILABILITY AND ACCESSIBILITY OF SERVICES, INCLUDING THE ADEQUACY OF THE PROVIDER NETWORK AS REFERENCED IN 42 CFR PARTS 438.604(A)(5); 438.606; 438.207(B) AND 438.206. SUBMISSION OF DOCUMENTATION WILL TAKE PLACE AS SPECIFIED BY THE STATE BUT NO LESS FREQUENTLY THAN THE FOLLOWING:

AT THE TIME PIHP ENTERS INTO A CONTRACT WITH THE STATE, ON AN ANNUAL BASIS OR ANYTIME THERE HAS BEEN SIGNIFICANT CHANGE (AS DEFINED BY THE STATE) IN PIHP OPERATIONS THAT WOULD AFFECT ADEQUACY OF CAPACITY AND SERVICES, INCLUDING CHANGES IN SERVICES, BENEFITS, GEOGRAPHIC SERVICE AREA, COMPOSITION OF OR PAYMENTS TO ITS PROVIDER NETWORKS, OR AT THE ENROLLMENT OF A NEW POPULATION. THE PIHP MUST SUBMIT ANY OTHER DATA, DOCUMENTATION, OR INFORMATION RELATING TO THE PERFORMANCE OF THE ENTITY'S OBLIGATIONS AS REQUIRED BY THE STATE AS REFERENCED IN 42 CFR PARTS 438.604(B) AND 438.606.

MDHHS/PIHP contract:
Schedule A. E. Access and Availability
Schedule A. E.6. Access and Availability
Schedule A. N. Provider Services

Provider_Credentialing_702781_7.pdf

Medicaid Provider Manual (Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter >> Section 15 HSW) MedicaidProviderManual.pdf (state.mi.us)

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the 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.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 applicants for provision of HSW services that meet initial credentialing standards prior to provider enrollment. Numerator: Number of applicants for provision of HSW services that meet initial credentialing standards prior to provider enrollment. Denominator: Number of HSW providers reviewed.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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 COMPLIANCE ISSUES FOR PROVIDER QUALIFICATIONS THAT WERE REMEDIATED WITHIN 90 DAYS. NUMERATOR: NUMBER OF COMPLIANCE ISSUES REMEDIATED WITHIN 90 DAYS. DENOMINATOR: ALL COMPLIANCE ISSUES.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

qualifications. Denominator: Number of non-licensed, non-certified waiver providers reviewed.

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

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

Data Aggregation and Analysis:

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

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:

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

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

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

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

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

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

		Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

The MDHHS site review process includes a full review on an annual basis and a follow-up review 90 days after the corrective action plan is approved. For performance measures related to timely remediation of issues of level of care, plan of service, and qualified providers, the same proportionate random sample used for the review is used. The data source is the plan of correction remediation evidence submitted by the PIHP/CMHSP for any issues identified during the review of the sample. Timely remediation is completed within 90 days after the PIHP/CMHSP's plan of correction has been approved by MDHHS for individual remediation and at the next annual PIHP/CMHSP site review for systemic remediation.

MDHHS and the PIHPs specifies provider network requirements. The PIHP is responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual / Behavioral Health Code Charts and Provider Qualifications requirements to provide services.

The annual MDHHS site reviews verify that the PIHP/CMHSPs have documentation of training required by policy, as published in the Behavioral Health Code Charts and Provider Qualifications. These reviews include discussions with PIHP/CMHSP staff, review of administrative policies and procedures, training, clinical record reviews, interviews with service recipients, and visits to some programs and residential sites.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Any findings noted during the site review process are included in a formal report issued by the MDHHS to the PIHP/CMHSP. If an immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP/CMHSP may be required. For all other identified individual issues, the PIHP/CMHSP is required to respond with a Corrective Action Plan (CAP) within 30 days of receiving the formal report. Members of the Site Review Team review the CAP and provide recommendations concerning their approval. Remediation of individual issues must be made by the PIHP/CMHSP, and evidence submitted to MDHHS staff within 90 days after the CAP has been approved by MDHHS. The MDHHS Site Review Team members conduct a follow-up on-site visit approximately 90 days after the Corrective Action Plan has been approved to assess the status and effectiveness of the PIHP/CMHSP's implementation of their submitted CAP for individual remediation of out of compliance issues. This visit also results in the issuing of formal correspondence to the PIHP/CMHSP. Implementation of systemic remediations will be reviewed at next annual PIHP/CMHSP site review to ensure all concerns have been appropriately addressed.

When the Site Review Team notes issues related to provider qualifications related to the waiver, the team leader informs the Federal Compliance Section Manager for follow-up, which may include providing training, consultation, or monitoring of PIHP follow-up.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

For Home and Community Based (HCB) setting compliance, residential settings included those that are provider-owned and operated and/or specialized adult foster care settings, PRIVATE FAMILY HOMES/NON-LICENSED SETTINGS and non-residential settings. included are community-based Community Living Supports (CLS), and Out of Home Non-Vocational Habilitation providers.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

PRIVATE FAMILY HOMES AND NON-RESIDENTIAL SETTINGS WHERE THE PERSON HOLDS A LEASE AND IS NOT PROVIDER OWNED AND OPERATED ARE PRESUMED TO BE HOME AND COMMUNITY BASED. SETTINGS THAT ARE PROVIDER OWNED/ OPERATED AND /OR SPECIALIZED ADULT FOSTER CARE have completed a rigorous review and remediation/validation process consisting of a survey and site review to ensure that these settings meet the home and community-based services (HCBS) settings rule. through the survey and site review process, any setting deemed noncompliant with the HCBS rule was remediated and reviewed to confirm compliance by March 17, 2023, any setting that was found compliant was validated to ensure accuracy. in addition, MDHHS required that any newly contracted setting prior to the March 17, 2023, date, must be fully compliant with the HCBS rule prior to contracting with the PIHP. this is accomplished through the provisional approval process that requires the PIHP to conduct a thorough review to ensure the setting is fully compliant prior to the settings approval to provide Medicaid funded HCBS services. this review includes an onsite assessment which includes a physical inspection of the setting, documentation review, REVIEW OF SETTING policies and procedures and staff interviews to ensure compliance with MDHHS HCBS requirements.

If a setting is not fully compliant the PIHP will work with the setting to ensure remediation is conducted and MAY THEN CONDUCT A SECOND PROVISIONAL REVIEW AS NEEDED PRIOR TO IDENTIFYING THE SETTING AS HCBS COMPLAINT. THE SETTING WILL BE MONITORED on an ongoing basis to ensure continued compliance.

Ongoing monitoring and compliance includes the following processes implemented by MDHHS to ensure compliance with the HCBS rule:

-The PIHPs are contractually obligated to ensure their HCBS provider network is compliant with the rule. Initially, at the time of contract renewal each setting must be found fully compliant with the HCBS rule and the PIHPs must complete the following monitoring processes:
-Annual physical assessments (in-person physical inspection) of each setting and
-Triennial comprehensive assessments (documentation review of beneficiary records and setting policies and procedures) for each waiver participant.
-MDHHS will utilize its site review process to ensure compliance.
-Additional performance measures have been instituted in the current waiver application to be reviewed annually to monitor setting compliance.
-Any areas of noncompliance will require remediation, within MDHHS established time frame.
-The PIHPs will report on assessment progress and compliance status on a quarterly basis on a triennial cycle for each waver participant served within the region.
-The PIHPs and their affiliated CMHSPs or contracted providers must have effective administrative policies regarding the HCBS compliance and monitoring process.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☑ **Each individual has privacy in their sleeping or living unit:**

- ☑ **Units have entrance doors lockable by the individual.**
- ☑ **Only appropriate staff have keys to unit entrance doors.**
- ☑ **Individuals sharing units have a choice of roommates in that setting.**
- ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Plan of Services (IPOS)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

If the beneficiary chooses to not have a supports coordinator, there are a number of alternatives available for assisting the beneficiary with the development of the IPOS. the beneficiary could also choose a supports coordinator assistant or an independent service and supports broker to help with developing the IPOS.

The PIHPs delegate the responsibilities of plan development and monitoring to CMHSP, or contracted provider chosen by the individual or family. Michigan's providers, including CMHSPs in their role as provider, may not offer both service planning and direct services to the same beneficiary without an only willing and qualified provider designation. See section D.1.b for more information about conflicts of interest.

Qualifications:
Supports coordinator assistants and independent services and supports brokers: minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.
ALL SUPPORTS COORDINATOR ASSISTANTS AND INDEPENDENT SERVICES AND SUPPORTS BROKERS MUST BE TRAINED IN THE HCBS RULE REQUIREMENTS (THIS INCLUDES BOTH SETTING AND CORE RIGHTS PROTECTIONS) COMPLETED AT HIRE AND ANNUALLY THEREAFTER.

If the beneficiary wants another provider instead of a supports coordinator or supports coordinator assistant or independent supports broker, the PIHP will assist the beneficiary to identify a provider within the network (or enroll a qualified provider upon request if possible) who possesses equal qualifications to a supports coordinator.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

THE STATE HAS CHOSEN TO LEVERAGE THE OPTION OF ALLOWING FOR ONLY WILLING AND QUALIFIED ENTITIES TO PROVIDE DIRECT SERVICES AND PERFORM ASSESSMENT AND PLANS OF CARE IN A GEOGRAPHICAL AREA.

WHEN PROVIDERS OF DIRECT SERVICE ARE GIVEN RESPONSIBILITY TO PERFORM ASSESSMENTS AND PLANS OF CARE, THEY MUST BE THE ONLY WILLING AND QUALIFIED ENTITY IN A GEOGRAPHICAL AREA.

THE ONLY WILLING AND QUALIFIED PROVIDER DESIGNATIONS ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:
1A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA
1B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TO INDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES TRIBAL PROVIDERS)
2: PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS
3: PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES "LACK OF OTHER DIRECT SERVICE PROVIDERS")

THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED.

CONFLICT OF INTEREST PROTECTIONS: MDHHS IS RESPONSIBLE FOR IDENTIFYING QUALIFIED PROVIDERS TO RECEIVE A OWQP DESIGNATION USING CLEAR AND PUBLISHED SET OF CRITERIA. MDHHS FACILITATES THE OWQP DESIGNATION PROCESS EVERY THREE YEARS.
A. MDHHS DEFINES THE CRITERIA FOR OWQP DESIGNEES, COMPLIANCE EXPECTATIONS AND REQUIREMENTS, INCLUDING ACCEPTABLE SAFEGUARDS TO LIMIT CONFLICTS OF INTEREST.
B. MDHHS WILL DIRECTLY OVERSEE AND MONITOR OWQP DESIGNATIONS THROUGH STATE POLICY, MEDICAID PROVIDER MANUAL LANGUAGE, CONTRACT LANGUAGE, SITE REVIEWS, AUDITS, AND DATA ANALYSIS.
C. MDHHS MONITORING WILL INCLUDE ONGOING EFFORTS TO EXPAND THE PROVIDER NETWORK TO MAXIMIZE CHOICE FOR BENEFICIARIES.
D. MDHHS CONDUCTS RETROSPECTIVE REVIEWS OF OWQP DESIGNATION APPLICATIONS FOR COMPLIANCE.

1.ONLY-WILLING-AND-QUALIFIED PROVIDER (OWQP): PROVIDERS WITH MDHHS-APPROVED OWQP DESIGNATION MUST ESTABLISH AND ATTEST TO SAFEGUARDS TO PROTECT AGAINST CONFLICTS OF INTERESTS. SAFEGUARDS REQUIRED FOR MDHHS-APPROVED OWQP DESIGNEES MUST INCLUDE, AT MINIMUM:
A. AN OPPORTUNITY FOR THE PARTICIPANT TO DISPUTE THE STATE'S ASSERTION THAT THE CASE MANAGEMENT ENTITY IS THE ONLY WILLING AND QUALIFIED PROVIDER THROUGH AN ALTERNATIVE DISPUTE RESOLUTION PROCESS;
B. ANNUAL EVALUATION BY A STATE AGENCY (MDHHS);
C. ADMINISTRATIVELY SEPARATE THE PLAN DEVELOPMENT FUNCTION FROM THE DIRECT SERVICE PROVIDER FUNCTIONS (INCLUDING OVERSIGHT BY SEPARATE SUPERVISORS);
D. REQUIRE THE INDIVIDUAL CONDUCTING SERVICE PLANNING OR ELIGIBILITY/NEEDS ASSESSMENT IS NOT THE SAME INDIVIDUAL PROVIDING DIRECT SERVICE.

2.OVERALL STRUCTURE: MICHIGAN'S PROVIDERS, INCLUDING CMHSPS IN THEIR ROLE AS PROVIDER, MAY NOT OFFER BOTH SERVICE PLANNING AND DIRECT SERVICES TO THE SAME BENEFICIARY WITHOUT AN OWQP DESIGNATION. TO BE COMPLIANT WITH CFA&P REQUIREMENTS, CMHSPS MUST ARRANGE THEMSELVES IN ONE OF TWO SCENARIOS OR RECEIVE AN OWQP DESIGNATION AS THE THIRD SCENARIO.
A. SCENARIO 1: THE CMHSP CONTRACTS OUT BOTH SERVICE PLANNING AND DIRECT SERVICE FUNCTIONS TO PROVIDERS. THE CMHSP MUST ENSURE THAT A MEMBER IS REFERRED TO

PROVIDER
A FOR SERVICE PLANNING AND A SEPARATE PROVIDER B FOR DIRECT SERVICES.
B. SCENARIO 2: THE CMHSP DIRECTLY OFFERS BOTH SERVICE PLANNING AND DIRECT SERVICES AND CONTRACTS WITH PROVIDERS FOR THESE FUNCTIONS. THE CMHSP MAY CONTINUE TO
PROVIDE SERVICE PLANNING OR DIRECT SERVICES TO A SINGLE MEMBER BUT MUST ENSURE A MEMBER IS REFERRED TO A SEPARATE PROVIDER A TO CONDUCT THE REMAINING FUNCTION.
C. SCENARIO 3: SEE INFORMATION ABOVE ON OWQP DESIGNATION.

3.THE PIHPS DELEGATE THE RESPONSIBILITIES OF PLAN DEVELOPMENT AND MONITORING TO CMHSP, OR CONTRACTED PROVIDER CHOSEN BY THE INDIVIDUAL OR FAMILY.

4.OVERALL SAFEGUARDS: MDHHS REQUIRES SAFEGUARDS AT SEVERAL LAYERS TO PROTECT AGAINST CONFLICTS OF INTEREST. SAFEGUARDS ARE IMPLEMENTED TO DEFINE, IDENTIFY, MITIGATE, AND
MONITOR POTENTIAL OR ACTUAL CONFLICTS OF INTEREST.
A. MDHHS OVERSEES THE DEVELOPMENT OF IMPLEMENTATION PLANS TO ACCOMPLISH THE MDHHS ESTABLISHED SAFEGUARDS.
B. THE FOLLOWING SAFEGUARDS ARE IDENTIFIED IN CONTRACTS.
I. MDHHS CONTRACTS WITH PIHPS RESTRICTS THE ENTITY (I.E., CMHSP OR CONTRACTED PROVIDER) THAT DEVELOPS THE PERSON-CENTERED SERVICE PLAN FROM PROVIDING
SERVICES WITHOUT THE DIRECT APPROVAL OF THE STATE.
II. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO MAINTAIN AND PUBLISH A COMPLETE PROVIDER DIRECTORY, INCLUDING INDEPENDENT FACILITATORS, IN HARD COPY AND WEB-BASED
FORMATS. INFORMATION MUST BE UPDATED ON AN ONGOING BASIS TO MAINTAIN ACCURACY.
III.MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO BE RESPONSIBLE FOR UTILIZATION MANAGEMENT OF SERVICES COVERED UNDER THE SCOPE OF CFA&P IMPLEMENTATION. THE PIHP
CANNOT DELEGATE THEIR AUTHORIZATION AND UTILIZATION MANAGEMENT RESPONSIBILITIES TO OTHER ENTITIES.
IV. MDHHS CONTRACTS WITH PIHPS REQUIRE THEM TO PROVIDE FULL DISCLOSURE TO BENEFICIARIES AND ASSURANCE THAT BENEFICIARIES ARE SUPPORTED IN EXERCISING THEIR RIGHT
TO FREE CHOICE OF PROVIDERS AND ARE PROVIDED INFORMATION ABOUT THE FULL RANGE OF WAIVER SERVICES, NOT JUST THE SERVICES FURNISHED BY THE ENTITY THAT IS
RESPONSIBLE FOR THE SERVICE PLAN DEVELOPMENT.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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)the supports and information that are made available to the beneficiary (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process.

The Michigan Mental Health Code requires that the service plan (individual plan of services or IPOS) be developed through a person-centered planning (PCP) process. Michigan law and policy provide guidance as to how PCP is implemented, including Administrative Regulations and the MDHHS/PIHP contract attachment entitled "Person Centered Planning Policy ". The PIHPs delegate the development and monitoring of the IPOS to CMHSPs or subcontracted providers who are responsible for supporting each beneficiary to CO-DESIGN the IPOS through the PCP process. Each agency is required to describe the process through the Customer Services Handbook. Each beneficiary is offered supports coordination OR INTENSIVE CARE COORDINATION WITH WRAPAROUND (ICCW) to support THEM with the planning development and implementation of THEIR services and supports. If THE BENEFICIARY PREFERS AN INDEPENDENT FACILITATOR TO ASSIST THEM IN DEVELOPING THE IPOS, THE PIHP CUSTOMER SERVICES UNIT MAINTAINS A LIST OF PERSON-CENTERED PLANNING (PCP) INDEPENDENT FACILITATORS [MDHHS/PIHP CONTRACT - CUSTOMER SERVICE STANDARDS POLICY]. THERE MAY BE CIRCUMSTANCE THAT THE CMHSP/PROVIDER IS THE ONLY WILLING AND QUALIFIED PROVIDER, THEY MUST IMPLEMENT NEW POLICIES/PROCEDURES TO FOLLOW SAFEGUARDS DEVELOPED BY MDHHS. SERVICES AND SUPPORTS MUST BE AVAILABLE ACROSS ALL GEOGRAPHIC AREAS ARE ENCOURAGED TO CONTRACT WITH PROVIDERS FROM OUTSIDE OF THEIR REGION IN ORDER TO MAINTAIN NETWORK CAPACITY TO MEET SUPPORT SERVICE NEEDS. UTILIZATION MANAGEMENT WILL BE MAINTAINED BY THE PIHP.

The following essential elements of the PCP process have been identified to measure the effectiveness of the process in ensuring that beneficiaries are directly and actively engaged:

Person-Directed. The beneficiary directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

Person-Centered. The planning process focuses on the beneficiary, not the system or the beneficiary's family, guardian, or friends. The beneficiary's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the beneficiary's needs or choices, rather than viewed as an annual event.

Outcome-Based. The beneficiary identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

Information, Support and Accommodations. As needed, the beneficiary receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the beneficiary to participate in the process are provided. The beneficiary is offered information on the full range of services available in an easy-to-understand format.

Independent Facilitation. Beneficiaries have the information and support to choose an independent facilitator to assist them in the planning process THROUGH THEIR CASE MANAGER, OTHER SERVICE PROVIDER OR AN ADVOCACY AGENCY TO PROVIDE A LIST OF NAMES AND RESUMES OF FACILITATORS OR FIND MORE INFORMATION ON STATE OF MICHIGAN'S PERSON-CENTERED PLANNING WEBSITE. THIS OFFERS THE BENEFICIARY CHOICE WITHOUT POSSIBLE PIHP INFLUENCE. INDEPENDENT FACILITATORS DO NOT DECIDE WHAT WILL BE PAID FOR IN THE PLAN, AUTHORIZE SERVICES AND SUPPORTS, OR BENEFIT FROM THE OUTCOME OF THE PLAN.

Pre-Planning. The purpose of pre-planning is for the beneficiary to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each beneficiary must use pre-planning to ensure successful PCP. Pre- planning, as individualized for the beneficiary's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired beneficiaries):
-When and where the meeting will be held.
-Who will be invited (including whether the beneficiary has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).

-Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for beneficiaries in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.
-The specific PCP format or tool chosen by the person to be used for PCP.
-What accommodations the beneficiary may need to meaningfully participate in the meeting (including assistance for beneficiaries who use behavior as communication).
-Who will facilitate the meeting.
-Who will take notes about what is discussed at the meeting.

(b) the beneficiary's authority to determine who is included in the process.

As described in (a) above, the beneficiary has full authority to decide who is involved in the process. Through the pre-planning process, the beneficiary identifies allies (friends, family members, staff, professionals) that he or she wants to be involved and schedules the planning process to accommodate him or her.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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

IN URGENT SITUATIONS A PRELIMINARY PLAN SHOULD BE DEVELOPED IN ORDER TO INITIATE SERVICES IMMEDIATELY FOR THE BENEFICIARY. THIS PLAN MUST BE DEVELOPED WITHIN 7 DAYS OF THE COMMENCEMENT OF SERVICES. A MORE DETAILED PLAN SHOULD BE COMPLETED WITHIN 30 DAYS OF THE PRELIMINARY PLAN THAT WILL PROVIDE THE OPPORTUNITY TO CREATE A MORE DETAILED AND FINALIZED IPOS.

The plan is co-designed by the beneficiary the plan facilitator (case manager/supports coordinator/ICCW or independent facilitator), friends, family members, paid staff and others chosen by the beneficiary (collectively called "allies") using the person-centered planning process. The plan facilitator is ultimately responsible for the development of the IPOS. The case management, supports coordination or ICCW entity is responsible for the implementation of the IPOS or person-centered service plan. After completing the eligibility determination and initial assessment, pre-planning session(s) occurs before the person-centered planning meeting. During pre-planning, the beneficiary 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. Robust planning concludes with a final person-centered planning meeting that finalizes what is included in the IPOS updated within 365 calendar days. The beneficiary must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the final PCP meeting and must be signed and agreed upon by the beneficiary and/or their legal representative. Once an IPOS has been developed through the co-designed PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's needs, changes in the beneficiary's condition as determined through the PCP process or changes in the personal preferences for support). The beneficiary and his or her case manager/supports coordinator/ICCW should work on and review the IPOS on a routine basis as part of their regular conversations. A beneficiary or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the beneficiary and his/her guardian or authorized representative, if any, shall occur not less than annually (Michigan Department of Health and Human Services, Bureau of Specialty Behavioral Health Person-Centered Planning policy).

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status.

The assessment is completed adhering to the CFA&P requirements.

An assessment is conducted to determine functional eligibility for services and supports. The assessments necessary to determine level of care eligibility for the HSW are determined by the PIHP. A clinical assessment tool like the WHODAS 2.0 (for adults 18 and over) or MichiCANS (for children up to the age of 18) appropriate for beneficiaries with I/DD can be used to identify potential enrollees to HSW. MDHHS will begin utilizing an assessment for all beneficiaries with I/DD to identify those who may meet ICF LOC criteria to assist the PIHP/CMHSP/other subcontractor to identify potential enrollees onto the HSW. The use of this new I/DD assessment will improve the identification of beneficiaries who may have a need for HSW services prior to the formal enrollment process. In addition to the I/DD ELIGIBILITY assessment, a comprehensive biopsychosocial evaluation including assessment of the beneficiary's unique preferences, physical, social and emotional functioning, medication, physical environment, natural supports, and financial status. The beneficiary must be reassessed annually thereafter. Depending on the beneficiary, other assessments may be needed (PT, OT, Speech). Assessment of level of care for HSW eligibility is completed by a QIDP as noted in Appendix B.

(c) How the participant is informed of the services that are available under the waiver.

The beneficiary is informed of services available under the Habilitation Supports Waiver initially through an intake process and again through the pre-planning and PCP process and through other discussions with the supports coordinator. The beneficiary is also informed through the customer services handbook and other print materials available from the PIHP.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

By using the PCP process, the entire PCP team works to support the beneficiary to achieve his or her goals, preferences and meet his or her needs. The services and supports available in the HSW are offered and utilized as indicated by the beneficiary and/or their representative as a means to achieve the life goals indicated in the IPOS. The process is used to problem solve and balance appropriate autonomy with health and safety needs. Health care needs (wellness and well- being) are specifically addressed through the PCP process [MDHHS administrative rule 330.7199]. The beneficiary's unique preferences are discussed and captured in the IPOS to ensure that services delivery stays individualized and meaningful to the person served.

(e) how waiver and other services are coordinated.

The supports coordinators are responsible for ensuring that the waiver services, Medicaid services, and other community services are coordinated. If the beneficiary chooses to have a supports coordinator assistant or independent supports broker, the plan must indicate the responsibility for coordination in those roles and how they will differ from what the supports coordinator role is. The plan of service 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 and non-waiver service to be provided are included in the IPOS. The beneficiary 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 IPOS. Supports coordinators oversee the coordination of state plan, 1915(i)SPA and waiver services included in the IPOS. This oversight ensures that waiver services in the plan are not duplicative of similar state plan services available to or received by the beneficiary.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

Through the PCP process, the beneficiary, allies, and others at the meeting help in identifying who will be responsible for implementing and monitoring various components of the plan. The responsibilities are documented in the IPOS. The supports coordinator will typically coordinate waiver and other services to ensure services are being delivered as indicated in the plan, the beneficiary is satisfied with their services, the beneficiary's needs are met overall, and supports are effective in meeting the goals of the IPOS. The person-centered planning process is used to determine each person or entity responsible for each implementation role in the IPOS.

(g) how and when the plan is updated, including when the participant's needs change.

The IPOS is updated annually and periodically reviewed at regular intervals determined through the PCP process but must be reviewed and updated a minimum of once annually. An updated assessment must also be completed annually. Beneficiary satisfaction and progress must be documented through these formal reviews. Necessary changes noted through the review process will be made through addendums to the IPOS and as necessary.

The PCP process is an excellent forum for addressing changes in needs, problems in implementation, and other challenges that arise. A PCP meeting can be convened to address issues whenever the need arises and with whatever frequency is appropriate [MDHHS Administrative Rule 330.7199].

(h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person- centered service plan from the waiver participant or their legal representative.

THE PERSON-CENTERED PLAN MUST BE FINALIZED AND AGREED TO, WITH THE INFORMED CONSENT OF THE INDIVIDUAL AND THE LEGAL REPRESENTATIVE IF APPLICABLE IN WRITING. PROVIDERS RESPONSIBLE FOR IMPLEMENTATION OF THE PERSON-CENTERED PLAN MUST BE TRAINED PRIOR TO PROVIDING SERVICES TO THE INDIVIDUAL. A TRAINING DOCUMENT ATTACHED TO THE PLAN IS REQUIRED THAT VERIFIES THE PROVIDERS UNDERSTANDING AND REQUIREMENTS TO IMPLEMENT THE INDIVIDUAL'S IPOS. THIS DOCUMENT MUST BE SIGNED BY THE PROVIDER AND STAFF WHO ARE RESPONSIBLE TO IMPLEMENT THE PLAN OF SERVICE. A COPY OF THE PLAN IS DISTRIBUTED TO THE INDIVIDUAL AND ALL PROVIDERS RESPONSIBLE FOR ITS IMPLEMENTATION. TO THAT END, THE INDIVIDUAL IS ENCOURAGED TO CHOOSE TO RUN

THEIR PERSON-CENTERED PLANNING MEETING, HAVE AN INDEPENDENT FACILITATOR SUPPORT THEM TO RUN THEIR MEETING AND/OR CHOOSE THE PERSON THEY WOULD LIKE TO FACILITATE ON THEIR BEHALF. QUESTIONS AND DECISIONS ARE DIRECTED TO THE INDIVIDUAL THROUGHOUT THE PCP PROCESS; WITH HELP FROM THE INDIVIDUAL'S CHOSEN SUPPORTIVE DECISION MAKERS, IF DESIRED/NEEDED AND THE FINAL WRITTEN PLAN IS REVIEWED WITH THE PERSON AND THEN SIGNED AS A FINAL ACT OF INFORMED CONSENT.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☑ **Informed consent of the individual.**
- ☑ **An assurance that interventions and supports will cause no harm to the individual.**

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.

The PCP process is the main method through which issues related to risk are identified, strategies for mitigating risk are developed, and methods for monitoring are determined. THIS INCLUDES THE UTILIZATION OF ASSESSMENT TOOLS LIKE THE BIO-PSYCHOSOCIAL TO IDENTIFY POTENTIAL RISKS THE BENEFICIARY MAY HAVE. This process is described below in detail and it is effective because it involves the people most trusted and valued by the beneficiary, including family, friends and other allies. The process is an open one in which the pros and cons of alternatives can be discussed. In this manner, health and welfare issues are balanced with the beneficiary's right to make his or her own choices. Solutions to these health, safety and welfare issues are brought up, discussed and resolved to assure the health and welfare of the beneficiary in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction. In the person-centered planning process, the beneficiary is informed of identified potential risk(s) to enable the beneficiary to make informed decisions and choices with regard to these risks. Often the discussion leads to better alternatives that both meet the beneficiary needs and satisfy his or her NEEDS AND PERFERENCES.

A beneficiary may choose to address a sensitive health and welfare issue privately with the supports coordination provider, rather than within the group PCP process. Regardless of how it is done, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) has an obligation to ensure that all health and welfare issues are addressed. When the beneficiary makes a decision contrary to the recommendation of a member of his or her circle of support, the supports coordinator (or supports coordinator assistant or independent supports broker or other chosen qualified staff with this responsibility) must ensure that the beneficiary has information about all available options, documents the beneficiary choice, and revisits the issue as needed.

Sometimes, a beneficiary's choices about how their supports and services are provided cannot be supported by the HSW because the choices pose an imminent risk to the health and welfare of the beneficiary or others. However, these decisions are made as part of the planning process in which the beneficiary and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the beneficiary's needs and satisfy their dreams and goals. Beneficiary-approved risk strategies are documented and written into the IPOS. Beneficiaries may be required to acknowledge situations in which their choices pose risks for their health and welfare.

If the documented health or safety needs of an individual require restrictive interventions (modifications of the HCBS rule) this process will occur in the Person-Centered Planning meeting. All restrictive interventions will be written into the individual POS consistent with the requirements specified by the HCBS Final Rule and consistent with the HCBS chapter in the Medicaid Provider Manual.

Back-up plans provide alternative arrangements for the delivery of services that are critical to beneficiary well-being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them. A copy of the back-up plan should be provided to the beneficiary, left in the beneficiary's home, included in the beneficiary's case record, and given to applicable service providers. Back-up plans include developing lists of alternative qualified providers, using a provider agency, using informal supports, or alerting/contacting the supports coordinator when planned for services are not available. Additionally, emergency AND CRISIS plans are developed for each beneficiary that clearly describes a course of action when an emergency situation occurs with the beneficiary. Plans for emergencies are discussed and incorporated into the IPOS during the PCP process. In an effort to make improvements in the way back-up plans are developed with beneficiaries, agencies must monitor and track situations in which back-up plans are activated, as well as when they are successful or unsuccessful. MDHHS DOES AUDIT TO ENSURE EVIDENCE OF TRAINING ON EMERGENCY PROCEDURES WAS COMPLETED FOR EACH DIRECT CARE PROVIDER IN ORDER TO MITIGATE RISK. AND BENEFICIARY SPECIFIC EMERGENCY PROCEDURES ARE INCLUDED IN THE IPOS AND TRAINED TO THOSE SAME STAFF IN ORDER TO PREVENT CRISIS.

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.

IN MICHIGAN, ALL MEDICAID BENEFICIARIES WHO ARE PARTICIPANTS IN THE HSW HAVE A RIGHT UNDER THE FEDERAL BALANCED BUDGET ACT (BBA) OF 1997 (42 CFR §438.6) TO CHOOSE THE PROVIDERS OF THE SERVICES AND SUPPORTS THAT ARE IDENTIFIED IN THEIR INDIVIDUAL PLAN OF SERVICE (IPOS) TO THE EXTENT POSSIBLE AND APPROPRIATE. PIHPS OR THEIR SUBCONTRACTORS MUST PROVIDE INFORMATION TO BENEFICIARIES REGARDING ANY RESTRICTIONS ON THE BENEFICIARIES' FREEDOM OF CHOICE AMONG PROVIDERS IN THE NETWORK. QUALIFIED PROVIDERS CHOSEN BY THE BENEFICIARY, BUT WHICH ARE NOT CURRENTLY IN THE NETWORK OR ON THE PROVIDER PANEL CAN BE ADDED TO THE PROVIDER PANEL. WITHIN THE PIHP, CHOICE OF PROVIDERS MUST BE MAINTAINED AT THE PROVIDER LEVEL. THE BENEFICIARY MUST BE ABLE TO CHOOSE FROM AT LEAST TWO PROVIDERS OF EACH COVERED SUPPORT AND SERVICES AND MUST BE ABLE TO CHOOSE AN OUT-OF-NETWORK PROVIDER UNDER CERTAIN CIRCUMSTANCES (SEE 42 CFR §438.52(B)). CHOICE OF PROVIDERS IS ESSENTIAL TO ENSURING THAT BENEFICIARIES ARE SATISFIED WITH THEIR SERVICES AND SUPPORTS AND WHO PROVIDES THEM. FOR EXAMPLE, MOST PEOPLE HAVE STRONG PREFERENCES ABOUT WHO PROVIDES THEIR MOST INTIMATE PERSONAL CARE.

SERVICES ARE PROVIDED LOCALLY BY THE COMMUNITY MENTAL HEALTH SERVICES PROGRAMS (CMHSPS) OR ITS CONTRACTED PROVIDERS OF THE PIHP.

WHEN IT HAS BEEN DETERMINED THAT A BENEFICIARY HAS A NEED FOR A SERVICE THROUGH THE PCP PROCESS, A LIST OF SERVICE PROVIDERS WILL BE MADE AVAILABLE TO THE BENEFICIARY BY THE CASE MANAGEMENT ENTITY IN ORDER TO ASSIST THE BENEFICIARY IN CONNECTING WITH POTENTIAL SERVICE PROVIDERS AND TO ENSURE IMPLEMENTATION OF THE NEEDED SERVICE. PIHPS ARE REQUIRED TO HAVE A COMPREHENSIVE LIST OF SERVICES WITHIN THEIR PROVIDER NETWORK WHICH IDENTIFIES SERVICES PROVIDERS AT THE LOCAL LEVEL.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

THE RESPONSIBILITY FOR APPROVING THE INDIVIDUAL PLAN OF SERVICES (IPOS) IS DELEGATED TO THE PIHPS. EACH PIHP DEVELOPS ITS OWN PROCESS THAT BY WHICH IT APPROVES THE IPOS THAT IS IN COMPLIANCE WITH CONFLICT FREE REQUIREMENTS AND MPM POLICY REQUIREMENTS. THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDES OVERSIGHT OF THE IPOS APPROVAL PROCESS AND QUALITY OF THE IPOS THROUGH ITS MDHHS SITE REVIEW PROCESS AND DURING THE HSW INITIAL ENROLLMENT AND HSW RECERTIFICATION REVIEW. MDHHS RETROSPECTIVELY REVIEWS EVERY IPOS DURING THE ENROLLMENT AND RECERTIFICATION PROCESS. ONE HUNDRED PERCENT OF IPOS SUBMITTED DURING THE INTIAL ENROLLMENT PROCESS AND RECERTIFICATION PROCESS ARE REVIEWED BY MDHHS QIDP FOR COMPLIANCE. ANY DISCREPANCIES OR CONCERNS NOTED DURING MDHHS REVIEWS RESULTS IN TECHNICAL GUIDANCE BEING PROVIDED TO THE PIHP HSW LEAD.

THE MDHHS SITE REVIEW TEAM CONDUCTS ANNUAL AUDITS FOR EACH PIHP TO ENSURE IPOS HAVE BEEN DEVELOPED IN ACCORDANCE WITH MDHHS PERSON- CENTERED PLANNING POLICY REQUIREMENTS, CONFLICT FREE REQUIREMENTS AND MPM POLICY REQUIREMENTS. ANY DISCREPANCIES OR CONCERNS NOTED DURING MDHHS REVIEWS RESULTS IN TECHNICAL GUIDANCE BEING PROVIDED TO THE CMHSP/PIHP AND REQUIRES CORRECTIVE ACTION TO AMEND THE IPOS TO MEET MDHHS POLICY AND STANDARDS AND REQUIRES SYSTEMIC REMEDIATIONS.

PLEASE REFER TO APPENDIX H-1. A.I. FOR FURTHER DETAIL ON THE REQUIRED SAMPLING METHODOLOGY FOR PERFORMANCE MEASURES RELATED TO THIS REQUIREMENT.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

The PIHP is responsible for assuring that a written or electronic record of the beneficiary's IPOS is maintained for a minimum of three years as required by 45 CFR §92.42. Each PIHP determines the location for storing records and makes these records available for the State to review upon request. RECORDS MAY BE IN HARD COPY OR ELECTRONIC FORMAT AND WILL BE RETAINED UNTIL THE LAST DATE OF SERVICE, PLUS 10 YEARS. CONTRACT LANGUAGE: BENEFICIARY SERVICE RECORDS. CONTRACTOR MUST ENSURE THAT PROVIDERS ESTABLISH AND MAINTAIN A COMPREHENSIVE INDIVIDUAL SERVICE RECORD SYSTEM CONSISTENT WITH THE PROVISIONS OF MSA POLICY BULLETINS, AND APPROPRIATE STATE AND FEDERAL STATUTES. CONTRACTOR MUST ENSURE THAT PROVIDERS MAINTAIN IN A LEGIBLE MANNER, VIA HARD COPY OR ELECTRONIC STORAGE/IMAGING, RECIPIENT SERVICE RECORDS NECESSARY TO FULLY DISCLOSE AND DOCUMENT THE QUANTITY, QUALITY, APPROPRIATENESS, AND TIMELINESS OF SERVICES PROVIDED. THE RECORDS MUST BE RETAINED ACCORDING TO THE RETENTION SCHEDULES IN PLACE BY THE DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET (DTMB) GENERAL SCHEDULE #20 AT: HTTPS://WWW.MICHIGAN.GOV/DTMB/SERVICES/RECORDSMANAGEMENT/SCHEDULES/GSLOCAL. THIS REQUIREMENT MUST BE EXTENDED TO ALL OF CONTRACTOR'S PROVIDER AGENCIES.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PIHP is responsible for monitoring how the beneficiary implements services and supports, assuring that the funding is expended pursuant to the IPOS and individual budget and that risk management issues are addressed. The supports coordinator (or supports coordinator assistant, independent supports broker, or other qualified provider as selected by the beneficiary to provide these functions) will provide assistance to the beneficiary as requested or needed throughout the process of obtaining and implementing waiver services AND NON-WAIVER SERVICES. THE SC ALSO HAS A ROLE IN COORDINATING AND LINKING THE BENEFICIARY TO OTHER HEALTH SERVICES THAT MAY OR MAY NOT BE PROVIDED BY THE BEHAVIORAL HEALTH SYSTEM TO ENSURE THE BENEFICIARY IS RECEIVING ALL MEDICALLY NECESSARY SERVICES.

SUPPORTS COORDINATORS MONITOR CASES BY UTILIZING THE FOLLOWING METHODS TO ENSURE THAT WAIVER AND NON-WAIVER SERVICES, AND ANY OTHER HEALTH RELATED SERVICES ARE DELIVERED AS SPECIFIED IN THE IPOS. THESE METHODS INCLUDE BUT ARE NOT LIMITED TO IN-PERSON VISITS, FACE TO FACE CONTACTS (AUDIO-VISUAL), EMAILS, PHONE CALLS, CONTACTS WITH FAMILY, SUPPORT CIRCLE OR PROVIDERS, LETTERS OR DOCUMENTATION REVIEW. THESE MONITORING METHODS WILL ENSURE BENEFICIARIES HEALTH AND WELFARE ARE ADDRESSED AT ALL TIMES, ARE ABLE TO EXERCISE THEIR FREEDOM OF CHOICE OF PROVIDERS, HAVE ACCESS TO ALL SERVICES (WAIVER, NON-WAIVER, HEALTH, ETC.), SERVICES PROVIDED MEET THE BENEFICIARY'S NEED, AND IDENTIFIED BACK-UP PLANS ARE EFFECTIVE IF NEEDED /IMPLEMENTED TO MEET THE BENEFICIARY NEEDS. THE METHODS UTILIZED WILL BE DETERMINED THROUGH THE PERSON-CENTERED PLANNING PROCESS BASED ON WHAT IS MOST EFFECTIVE FOR THE BENEFICIARY.

MONITORING FREQUENCY IS DETERMINED THROUGH THE PERSON-CENTERED PLANNING PROCESS AND AT A MINIMUM SHOULD BE PERFORMED ON A MONTHLY BASIS. THROUGH THE PERSON-CENTERED PLANNING PROCESS, BENEFICIARIES AND THEIR FAMILIES DETERMINE THEIR PREFERENCE AS TO WHETHER SERVICES ARE PROVIDED IN-PERSON OR VIA TELE-HEALTH. IN-PERSON FACE-TO-FACE CONTACT MUST OCCUR AT A MINIMUM OF ONCE ANNUALLY.

IF ANY PROBLEMS ARE DISCOVERED DURING MONITORING, ISSUES ARE ADDRESSED IMMEDIATELY. IF SERVICES ARE NOT BEING IMPLEMENTED AS OUTLINED IN THE IPOS OR THE BENEFICIARY'S NEEDS ARE NOT BEING MET, A CORRECTIVE ACTION IS DEVELOPED BETWEEN THE BENEFICIARY AND PIHP TO REMEDY THE SITUATION. THE BENEFICIARY OR THEIR REPRESENTATIVE MUST APPROVE ALL CHANGES IN THE IPOS AND THE BENEFICIARY 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 BENEFICIARY, FAMILY, SERVICE PROVIDER, OR ANY OTHER INDIVIDUAL, THE PIHP WILL ACT IMMEDIATELY TO ENSURE THE HEALTH AND WELFARE OF THE BENEFICIARY. THE PIHP WILL PRESENT AND DISCUSS OPTIONS TO PROTECT THE BENEFICIARY TO THE BENEFICIARY AND THE BENEFICIARY'S CHOSEN ALLIES. ANY REVISIONS TO THE IPOS WILL BE IMPLEMENTED IMMEDIATELY AND FOLLOWED-UP ON REGULARLY. PIHPS ARE RESPONSIBLE FOR ON-GOING MONITORING OF SERVICE PLAN IMPLEMENTATION AND OF DIRECT SERVICE PROVIDERS. PIHPS CONDUCT A FORMAL ADMINISTRATIVE REVIEW ANNUALLY ACCORDING TO THE MDHHS MONITORING PLAN OF DIRECT SERVICE PROVIDERS.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and*

qualified entity in a geographic area who can monitor service plan implementation).

MDHHS as the state Medicaid agency will deliver HSW services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for development and monitoring person-centered service plans and the network's implementation of the HSW services, which require additional conflict of interest protections including separation of service planning and service delivery TO ALIGN WITH THE MDHHS-APPROVED CFA&P SCENARIOS, AS OUTLINED IN MDHHS' CFA&P REQUIREMENTS AND PIHP CONTRACTS.

IN RURAL AND/OR TRIBAL COMMUNITIES AND as outlined in MDHHS' Conflict- Free Access and Planning "Only-Willing and Qualified Provider Designation" Process and approved by CMS, the State may approve an entity to provide both service planning and direct waiver services to the same beneficiary. In those limited circumstances and as defined in MDHHS' "ONLY-WILLING AND QUALIFIED PROVIDER DESIGNATION" PROCESS, the entity must implement protections to mitigate conflict of interest. Utilization management will be maintained by the PIHP.

THE ONLY WILLING AND QUALIFIED PROVIDER DESIGNATIONS ARE EVALUATED FOR THE SPECIFIC GEOGRAPHICAL AREA OF EACH COUNTY. WITHIN THAT COUNTY, EACH PROVIDER IS EVALUATED ACCORDING TO THE FOLLOWING CRITERIA:
1A: PROVIDER IS LOCATED IN A RURAL COUNTY OF THE STATE, AS DEFINED BY MDHHS USING CENSUS BUREAU DATA; OR
1B: PROVIDER IS A TRIBAL PROVIDER WITH EXPERIENCE AND KNOWLEDGE TO PROVIDE SERVICES TO INDIVIDUALS WHO SHARE A COMMON CULTURAL BACKGROUND, (MDHHS DEFINES TRIBAL PROVIDERS); AND
2: PROVIDER IS THE ONLY ENTITY OFFERING SERVICE PLANNING IN THE COUNTY, AS IDENTIFIED IN SPECIFICATIONS DEFINED BY MDHHS
3: PROVIDER DELIVERS HCBS SERVICE(S) DUE TO LACK OF OTHER DIRECT SERVICE PROVIDERS IN THE COUNTY (MDHHS DEFINES "LACK OF OTHER DIRECT SERVICE PROVIDERS")
THE STATE WILL ENSURE THAT CONFLICT OF INTEREST PROTECTIONS WILL BE IMPLEMENTED.

The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS/PIHP contract, MDHHS delegates the responsibility for the authorization of the service plan to the PIHPs. The PIHPs delegate the responsibilities of plan development and monitoring to CMHSP and /or contracted provider supports coordinator or other qualified staff chosen by the beneficiary or family. The provider responsible for the IPOS are not providers of any HCBS for that beneficiary and are not the same provider responsible for the HCBS needs assessment. The CMHSPs/contracted providers authorize the implementation of service through a separate service provider entity.

The monitoring of implementation of the IPOS is done by the beneficiary's supports coordinator, supports coordinator assistant, or independent supports broker or other qualified provider chosen by the beneficiary, who may not provide other direct services to the beneficiary. In fact, all monitoring functions (supports coordination, recipient rights, etc.) are administratively separate from the service provision functions. In addition, a beneficiary may contract with an independent supports broker to assist the beneficiary with implementation of the IPOS.

To include an option for the participant to choose a different entity or individual to monitor the plan: MDHHS CONTRACT, PERSON-CENTERED PLANNING POLICY, AND SELF-DIRECTED SERVICES POLICY LANGUAGE REQUIRES PIHPS TO PUBLISH A COMPREHENSIVE AND ACCESSIBLE PROVIDER DIRECTORY, COMPLETE MEDICAID SERVICE ARRAY, AND BENEFICIARY'S RIGHTS INCLUDING RIGHTS TO ACQUIRE AN INDEPENDENT FACILITATOR AND TO ENGAGE SELF-DIRECTED SERVICE ARRANGEMENTS.

That direct oversight of the process: IN ADDITION TO REGULAR MDHHS AUDITING PROCESSES, PIHPS WILL BE CONTRACTUALLY REQUIRED TO MONITOR Only Willing and Qualified Provider (OWQP) DESIGNEES TO ENSURE THEY ARE IMPLEMENTING POLICIES AND PROCEDURES AS INTENDED. PIHPS MAY USE AUTHORIZATION DATA, SERVICE PLAN AUDITS, AND GRIEVANCE AND APPEALS DATA TO INFORM COMPLIANCE WITH OWQP DESIGNATIONS.

Regarding conducting an independent assessment of the effectiveness of monitoring or periodic evaluation by a state agency: MDHHS EVALUATES THE EFFECTIVENESS OF PIHP'S BENEFICIARY ENROLLMENT AND CERTIFICATION PROCESS WHICH INCLUDES A REVIEW OF THE SERVICE PLAN AND VERIFICATION OF

COMPLIANCE BY THE PIHP OF THESE REQUIREMENTS. IN ONGOING AUDITING PROCESSES, MDHHS REVIEWS THE APPROVED IMPLEMENTATION PLAN SUBMITTED BY THE PIHP FOR COMPLIANCE. ADDITIONALLY, MDHHS REVIEWS CLINICAL RECORDS IN A SITE REVIEW PROCESS. MDHHS IS DEVELOPING REPORTING CAPABILITIES AND INTEGRATING REPORTING INTO EXISTING STRUCTURES.

That restrict the entity that develops the plan from monitoring services without the direct approval of the state: ONLY CMHSPS/PROVIDERS WITH OWQP DESIGNATIONS MAY BE RESPONSIBLE FOR SERVICE PLAN MONITORING AND DIRECT SERVICES TO THE SAME BENEFICIARY. PROVIDERS/CMHSPS WITH OWQP DESIGNATIONS MUST ATTEST IN THEIR OWQP DESIGNATION APPLICATION THERE IS SEPARATION BETWEEN STAFF OFFERING SERVICE PLAN MONITORING AND STAFF OFFERING DIRECT SERVICES. ADDITIONALLY, THE PIHPS, ARE RESPONSIBLE FOR UTILIZATION MANAGEMENT FUNCTIONS, INCLUDING AUTHORIZATION OF THE SERVICE PLAN.

That require that agency monitoring functions be administratively separate from service provision functions: PROVIDERS/CMHSPS WITH OWQP DESIGNATIONS MUST ATTEST IN THEIR OWQP DESIGNATION APPLICATION THERE IS SEPARATION BETWEEN STAFF OFFERING SERVICE PLAN MONITORING AND STAFF OFFERING DIRECT SERVICES. METHODS TO ADMINISTRATIVELY SEPARATE SERVICE MONITORING FROM DIRECT SERVICE MUST BE APPROVED BY MDHHS THROUGH THE OWQP DESIGNATION APPLICATION PROCESS. PIHPS MUST VERIFY AND MONITOR THE ADEQUACY OF THE ADMINISTRATIVE SEPARATIONS OUTLINED BY THE CMHSP/PROVIDERS IN THEIR OWQP DESIGNATION APPLICATION.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 enrolled beneficiaries whose IPOS include services and supports that align with the beneficiary's assessed needs. Numerator: Number of enrolled beneficiaries whose IPOS include services and supports that align with their assessed needs. Denominator: All enrolled beneficiaries sampled.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled beneficiaries whose IPOS reflect their goals and preferences. Numerator: Number of enrolled beneficiaries whose IPOS reflect their goals and preferences. Denominator: All enrolled beneficiaries sampled.

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

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

		Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled beneficiaries whose IPOS had adequate strategies to

address their assessed health and safety risks. Numerator: Number of enrolled beneficiaries whose IPOS had adequate strategies to address their assessed health and safety risks. Denominator: All enrolled beneficiaries sampled.

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

Performance Measure:
Number and percent of IPOS for enrolled beneficiaries that are developed in accordance with policies and procedures established by MDHHS. Numerator: Number of IPOS for enrolled beneficiaries that are developed in accordance with policies and procedures established by MDHHS. Denominator: All enrolled beneficiaries sampled.

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

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***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 enrolled beneficiaries whose IPOS changed when the individual's needs changed. Numerator: Number of enrolled beneficiaries whose IPOS was changed when the beneficiary's needs changed. Denominator: All enrolled beneficiaries sampled.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled beneficiaries whose IPOS are updated within 365 days of their last plan of service. Numerator: Number of enrolled beneficiaries whose IPOS were updated within 365 days of their last plan of service. Denominator: All enrolled beneficiaries sampled.

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: 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:
 # and % of IPOS for enrolled beneficiaries in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency. Numerator: Number of IPOS for enrolled beneficiaries with services and supports provided as specified in the plan, including type, amount, scope, duration and frequency. Denominator: All IPOS for enrolled beneficiaries sampled.

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

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

		95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***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 enrolled beneficiaries who are informed of their right to choose among the various waiver services. Numerator: Number of enrolled beneficiaries who are informed of their right to choose among the various waiver services. Denominator: All enrolled beneficiaries sampled.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled beneficiaries who are informed of their right to choose among waiver providers. Numerator: Number of enrolled beneficiaries who are informed of their right to choose among waiver providers. Denominator: All enrolled beneficiaries sampled.

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

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

		Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

A proportionate random sample will be obtained to assure that HSW beneficiaries receiving services at each PIHP are reviewed.

In addition to the MDHHS site reviews, the Federal Compliance Section staff may identify issues related to the IPOS through activities such as reviews of HSW applications, monitoring the HSW database for timeliness of consents for freedom of choice, reviewing requests for Medicaid fair hearing on HSW-related services, and numerous requests for technical assistance by PIHPs, CMSHPs, providers, HSW beneficiaries and their families.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Any findings noted during the site review process are included in a formal report issued by MDHHS to the PIHP/CMHSP. If an immediate need for action is noted by the Site Review Team related to these assurances, an immediate review and response by the PIHP/CMHSP may be required. The findings of each PIHP/CMHSP site review are sent to the PIHP/CMHSPs with the requirement that the PIHP/CMHSP prepare and submit to MDHHS a Corrective Action Plan (CAP) within 30 days. The CAP is reviewed by staff that completed the site reviews and reviewed and approved by MDHHS administration. MDHHS follow-up is conducted to ensure that individual remediation of out-of-compliance issues occurs within 90 days after the CAP is approved by MDHHS. Implementation of systemic remediations will be reviewed at next annual PIHP/CMHSP site review to ensure all concerns have been appropriately addressed. This visit also results in the issuing of formal correspondence to the PIHP.

Additionally, when individual problems are discovered by either the MDHHS site review or by the HSW Program staff, that issue is addressed directly with the HSW coordinator at the PIHP to determine how to 1) resolve the issue for that individual and 2) provide any needed technical assistance or training at the regional or local level.

Documentation of individual actions may be in the form of emails, fax transmittals, phone calls, training logs or visits to an HSW beneficiary's home.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

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.

(a) The nature of the opportunities afforded to beneficiary:

All beneficiaries served through specialty mental health are afforded the opportunity to self-direct their services. Beneficiaries have opportunities for both employer and budget authority. Beneficiaries may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. The beneficiary may direct the budget and directly contract with chosen providers. The individual budget is transferred to a financial management services provider which administers the funds and makes payment upon beneficiary authorization.

There are two options for beneficiaries choosing to directly employ workers: Self-Directed Services/Choice Voucher System and Agency Supported Self-Direction. Through the first option, the beneficiary is the common law employer and delegates performance of the fiscal/employer agent functions to the financial management service, which processes payroll and performs other administrative and support functions through Self-Directed Services, Choice Voucher is for Children on the waiver where a legal guardian would perform the functions of a common law employer on behalf of the child. The beneficiary directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Self-Direction Technical Requirement Implementation Guide. In the Agency Supported Self-Direction model, beneficiaries may contract with an agency which supports self-direction and split the employer duties with the agency. The beneficiary is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the beneficiary. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Self-Direction Technical Requirement Implementation Guide. A beneficiary may select one or both options. For example, a beneficiary may want to use self-directed services to directly employ a good friend to provide CLS during the week and an agency which supports self-direction to provide CLS on the weekends. The Customer Services Handbook, which includes information about self-directed services, is disseminated to all beneficiaries of mental health services and is provided at the onset of services.

(b) How beneficiaries may take advantage of these opportunities

Information about self-directed services is also provided by the supports coordinator (or other QIDP) to all HSW-enrolled beneficiaries and their families - at initial enrollment and on an on-going basis. Beneficiaries interested in arrangements that support self-determination start the process by letting their supports coordinator or other chosen qualified provider know of their interest. The beneficiaries are given information regarding the responsibilities, liabilities and benefits of self-direction prior to the PCP process. An individual plan of service (IPOS) will be developed through this process with the beneficiary, supports coordinator or other chosen qualified provider, and allies chosen by the beneficiary. The plan will include the HSW waiver services needed by and appropriate for the beneficiary. An individual budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The beneficiary will choose service providers and act as the employer. In Michigan, PIHPs provide many options for beneficiaries to obtain assistance and support in implementing their arrangements.

(c) The entities that support beneficiaries who direct their services and the supports that they provide

Supports coordinators, supports coordinator assistants, or independent support brokers (or other qualified provider chosen by the beneficiary) are responsible for providing support to beneficiaries in arrangements that support self-determination by working with them through the PCP process to develop an IPOS and an individual budget. The supports coordinator, supports coordinator assistant, or independent supports broker is responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and arrangements. Supports coordinators, supports coordinator assistants, or independent supports brokers (or other qualified provider chosen by the beneficiary) make sure that beneficiaries receive the services to which they are entitled and that the arrangements are implemented smoothly. Beneficiaries are provided many options for Independent Advocacy, through involvement of a network of beneficiary allies and independent supports brokerage, which are described in Section E-1k below.

Through its contract with MDHHS, each PIHP and PIHP contracted network provider is required to offer information and education to beneficiaries on beneficiary direction. Each PIHP and PIHP contracted network provider also offers support to beneficiaries and their families who choose self-direction. This support should include offering peer-to-peer discussion forums on how to be a better employer, offering the required staff qualification training for workers, or providing one-on-one assistance when a problem arises.

Each PIHP is required to contract with one or more financial management service providers. Financial Management

Services is a service in the HSW. Financial Management Services perform a number of essential tasks to support beneficiary direction while assuring accountability for the public funds allotted to support those arrangements. The financial management service has four basic areas of performance:

- function as the employer agent for beneficiaries directly employing workers to assure compliance with payroll tax and insurance requirements;
- ensure compliance with requirements related to management of public funds, the direct employment of workers by beneficiaries, and contracting for other authorized goods and services.
- facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to beneficiary and agency; and
- offer supportive services to enable beneficiaries to direct the services and supports they need.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ● **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ● **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery**

methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Although all beneficiaries are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the beneficiary or their representative. While beneficiaries have the right to choose among service providers who are on contract with or employed by the PIHP or hired through Self Directed service, the following three waiver services are considered provider managed services only: 1. Environmental Modification, 2. Enhanced Medical equipment and Supplies, VEHICLE MODIFICATION and 3. Financial Management Services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The information about participant direction opportunities (e.g., the benefits of participant direction, 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.

The PIHPs are responsible for providing information about participant direction opportunities. General information about self-directed services is made available to all waiver beneficiaries (new and current) by providing them with a general brochure and with directions how to obtain more detailed information. When a person receiving waiver services expresses interest in participating in arrangements that support self-determination, the supports coordinator, supports coordinator assistant, independent supports broker, or other qualified provider as selected by the beneficiary, who has specific training and expertise in the various options available, will assist the beneficiary in gaining an understanding about self-determination arrangements and how those might work for the beneficiary. Many PIHPs have a Self-Determination Coordinator who has expertise in arrangements that promote self-determination.
Specific options and concerns such as the benefits of participant-direction, consumer responsibilities and potential liabilities are addressed through the person-centered planning process, which is mandated in the Mental Health Code. Each beneficiary develops an Individual Plan of Service (IPOS) through the person-centered planning (PCP) process, which involves his or her family and friends and a case manager (or other QIDP). The IPOS developed through this process addresses potential liabilities and ensures that the concerns and issues are planned for and resolved. The PCP Policy and Practice Guideline require that health and safety concerns be addressed. The MDHHS Self Determination staff provide support and technical guidance to CMHSPs with developing local capacity and with implementing options for participant direction.

(b) the entity or entities responsible for furnishing this information

The PIHPs are responsible for disseminating this information to beneficiaries and their representatives. In addition, the program staff from MDHHS provide information and training to provider agencies, advocates and other community partners.

(c) how and when this information is provided on a timely basis

This information is provided throughout the beneficiary's involvement with the PIHP. It starts from the time that the beneficiary approaches the PIHP for services and is provided with information regarding options for beneficiary direction. Beneficiaries to be provided with information about the principles of self-determination and the possibilities, models and arrangements of self-directed services. The PCP process is a critical time to address issues related to beneficiary direction including methods used, health and welfare issues, and the involvement of informal supports. Follow-up information and assistance is available at any time to assure that beneficiary concerns and needs are addressed. Self-determination arrangements begin when the PIHP and the beneficiary reach an agreement on an individual plan of service, the funding authorized to accomplish the plan, and the arrangements through which the plan will be implemented. Each beneficiary (or his or her legal representative) who chooses to direct his or her services and supports signs a Self-Determination Agreement with the PIHP 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 beneficiaries, can be an important resource for the beneficiary. These informal supports can include agents designated under a power of attorney or other identified persons participating in the PCP process. The involvement of a number of allies in the process ensures that the representative will work in the best interests of the beneficiary. THIS IS KNOWN AS SUPPORTED DECISION MAKING AND DOES NOT REQUIRE A FORMAL PROCESS AS THE INDIVIDUAL WILL CONTINUE TO MAKE DECISIONS WITH HELP JUST AS ANYONE ELSE WOULD DO. A NON-LEGAL REPRESENTATIVE WHO WILL BE TAKING OVER SPECIFIC DUTIES IN THE SELF-DIRECTED ARRANGEMENT WILL BE IDENTIFIED IN THE SD AGREEMENT AS TO THEIR SPECIFIC ROLE(S) AND RESPONSIBILITY. THIS REPRESENTATIVE WILL BE CHOSEN BY THE INDIVIDUAL WITH SUPPORT IF DESIRED, OR BY THE INDIVIDUAL'S LEGAL REPRESENTATIVE. THIS REPRESENTATIVE WILL BECOME PARTY TO THE AGREEMENT AND WILL HAVE PIHP OVERSIGHT TO ENSURE THE REPRESENTATIVE CONTINUES TO ACT IN GOOD FAITH WITHIN THE TERMS OF THE AGREEMENT AND IN THE BEST INTEREST OF THE BENEFICIARY.

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
Enhanced Pharmacy	☐	☑
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT	☑	☑
Respite	☑	☑
Community Living Supports	☑	☑
Goods and Services	☑	☑
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT	☑	☑
Personal Emergency Response System	☐	☑
Out-of-Home Non-Vocational Habilitation	☑	☑
Family Training	☑	☑
Non-Family Training	☑	☑
Private Duty Nursing	☑	☑
Overnight Health and Safety Support	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

● **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

FMS PROVIDERS ARE PROCURED THROUGH AN RFP PROCESS AND EVALUATED FOR SELECTION THROUGH FINANCIAL MANAGEMENT SERVICES READINESS REVIEW AS WELL AS MEETING THE MINIMUM OPERATIONAL REQUIREMENTS REQUIRED PER PIHP CONTRACT SPECIFIED IN 2 CFR 200, 45 CFR 92.40 AND 42 CFR 438.12.
A CONTRACT BETWEEN THE PIHP CONTRACTED NETWORK PROVIDER AND THE FMS IS DEVELOPED AND SIGNED THAT OUTLINES THE ROLES, RESPONSIBILITIES, BASIS AND PROCESS FOR PAYMENT.
The PIHP or the PIHP contracted network provider offers the beneficiary or legal guardian a choice among available FMS entities that meet the qualifications for this provider type. If the beneficiary's representative identifies a qualified FMS not currently on the provider panel, that FMS may apply to the PIHP or contracted network provider to be included on the provider panel.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

THE FMS GETS COMPENSATED VIA THE PIHP BILLED MONTHLY AS A WAIVER SERVICE FOR EACH BENEFICIARY. The contract between the PIHP and the FMS stipulates the conditions of the agreement including the role and responsibility of the FMS and how the FMS is compensated for the financial management services it provides.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**

☑ **Collect and process timesheets of support workers**

☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☑ **Other**

Specify:

The FMS must designate a liaison person who will be the primary contact person and have responsibility for monitoring and ensuring that the terms of the contract between the FMS and the CMHSP are fulfilled. Activities include:

1. To receive, safeguard, manage and account for funds provided by the PIHP on behalf of each beneficiary and maintain complete and current financial records and supporting documentation verifying expenditures paid by the FMS and a chart of accounts.

2. To assist beneficiary and their representatives to understand billing and documentation responsibilities.

3. To perform the financial administrative duties of employer and provide employer agent services to the beneficiary and his/her representative directly employing staff or contracting with clinical service providers. The FMS must abide by all federal and state laws regarding payroll taxes and shall remain current with all payroll tax requirements. Both the PIHP/CMHSP and the beneficiary or beneficiary's representative must provide copies of all required employment documents including the Medicaid Provider Agreement to the FMS.

4. To disburse funds to vendors and other providers of services and supports as directed by each beneficiary or beneficiary's representative for the services and supports selected by the beneficiary or beneficiary's representative and in accordance with the individual plan of services, only upon receipt of all required agreements including the Medicaid Provider Agreement and timesheets or invoices approved by the beneficiary as the Employer of Record or their Representative as the Managing Employer.

5. To maintain complete current financial records, copies of all agreements, and supporting documentation verifying expenditures paid by the FMS on behalf of each beneficiary. These records must be retained for seven years from the start of FMS services.

6. To record and maintain a monthly report of services and expenditures for each beneficiary to keep the PIHP/CMHSP and the beneficiary or beneficiary's representative informed of utilization and expenditures for services.

7. To safeguard all confidential information including the results of any background checks, and/or other documents pertaining to providers of services as needed or requested by the beneficiary or beneficiary's representative and/or the PIHP/CMHSP.

8. To flag for the CMHSP and the beneficiary or beneficiary's representative deviations in provision of services authorized in accordance with the individual plan of services.

9. To reconcile all accrued expenses/accounts payable by the end of the fiscal year.

10. To make records regarding beneficiary the self-directed arrangement available to the PIHP/CMHSP (on behalf of the State Medicaid Agency) as requested and to allow each beneficiary or beneficiary's representative access to his or her own records.

11. To commission a full financial audit of the FMS's books and records as required by the PIHP/CMHSP and/or MDHHS.

Supports furnished when the participant exercises budget authority:

- ☑ **Maintain a separate account for each participant's participant-directed budget**
- ☑ **Track and report participant funds, disbursements and the balance of participant funds**
- ☑ **Process and pay invoices for goods and services approved in the service plan**
- ☑ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☑ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☑ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) MDHHS requires that PIHP/CMHSPs develop and implement a plan for assessing and monitoring FI FMS performance that involves participants, participants' representatives and their allies in the assessment and monitoring. The plan should include a performance review process at least annually. Elements of the plan for assessing and monitoring FMS performance must minimally include:

1. Fulfillment of FMS Agreement requirements;

2. Competency in safeguarding, managing and disbursing funds;

3. Ability to indemnify the CMHSP pursuant to FMS agreement requirements;

4. Evaluation of consumer feedback and experience with and satisfaction of FMS performance with alternate methods for collecting data from beneficiaries;

5. Involvement of beneficiary and their allies in the development and implementation of the FI FMS arrangement; and

6. Performing an audit of a sample of service utilization and expenditure reports.

(b) The PIHP/CMHSPs are responsible for this monitoring. Compliance with the requirement is included in the MDHHS site review process.

(c) The FMS performance review must be conducted at least annually.

THE PIHPS ESTABLISH SPECIFIC REVIEW TEAMS TO PLAN, IMPLEMENT, AND CONDUCT MONITORING FOR 100% OF THEIR REGION'S CONTRACTED FMS PROVIDERS. PER POLICY, QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) STAFF SCHEDULES THE REVIEWS, SITE VISITS, COORDINATES ALL CORRESPONDENCE RELATED TO REVIEWS TO PROVIDERS, ALONG WITH SENDING FINAL REPORTS AND ENSURING ALL CORRECTIVE ACTION IS REVIEWED AND APPROVED IN A TIMELY MANNER. EACH REVIEW TEAM MEMBER REVIEWED ASSIGNED SECTIONS OF THE REVIEW. QAPIP COMBINES THE REVIEW DOCUMENTS AND SENDS THE FINAL REPORT DRAFT FOR TEAM APPROVAL. ONCE APPROVED, THE FINAL REPORT WAS SENT TO THE FMS WITH REQUESTS FOR CORRECTIVE ACTION PLANS, AS APPLICABLE.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Specific options for participant direction are addressed through the person-centered planning process (PCP), which is mandated in the Michigan Mental Health Code. Each beneficiary CO-DESIGNS an Individual Plan of Service (IPOS) through the PCP process, which involves his or her family and friends and a supports coordinator or other qualified provider (such as an independent supports broker). For minor children and their families, this planning process includes a family-driven/youth-guided practice that builds upon the child's capacity to engage in activities to promote health, safety, habilitation, skill development, and participation in community life. The process honors the preferences, choices and abilities of the child and the family and involves the participation of the child, family and friends. This process results in an IPOS for the child that describes the services and supports that will be used to promote health and safety and achieve the identified preferences, choices, dreams and goals.

When a beneficiary expresses interest in self-directing services, the supports coordinator (or other person selected by the beneficiary or their representative) will assist the person in gaining an understanding about self-directed services and how those options might work for the beneficiary. This includes providing information regarding the responsibilities, liabilities and benefits of these options prior to the PCP process. The IPOS will include the waiver services needed by and appropriate for the beneficiary. A budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS. The beneficiary or their representative will be informed of qualified financial management services (FMS) on contract with the PIHP/CMHSP.

Depending on the need of the beneficiary, the supports coordinator, ASSISTANT OR BROKER may provide a variety of information and assistance related to implementing SELF- direction. When staff are hired, the supports coordinator, ASSISTANT OR BROKER may troubleshoot staff performance problems or-in the case of purchase of service arrangements for clinical service providers-the case manager may troubleshoot services, e.g., scheduling.

☑ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Enhanced Pharmacy	☐
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT	☐
Respite	☐
Community Living Supports	☐
Goods and Services	☐
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT	☐
Environmental Modifications	☐
Personal Emergency Response System	☐
Out-of-Home Non-Vocational Habilitation	☐
Family Training	☐
VEHICLE MODIFICATION	☐
Financial Management Services	☑
Non-Family Training	☐
Enhanced Medical Equipment and Supplies	☐
Private Duty Nursing	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Overnight Health and Safety Support	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ◉ **No. Arrangements have not been made for independent advocacy.**
- ○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The beneficiary has the freedom to modify or terminate his or her arrangements that support self-determination at any time. The most effective method for making changes is through the person-centered / family-driven / youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement. The decision of a beneficiary to terminate participant direction does not alter the need for services as identified in the IPOS.

THE PIHP/CMHSP MUST HAVE A BACK UP PLAN READY FOR SUCH TIME THAT AN ARRANGEMENT IS TERMINATED AND WILL ENCOURAGE THE BENEFICIARY TO NOTIFY THE CMHSP OF INTENT TO TERMINATE WITH AS MUCH FOREWARNING AS POSSIBLE TO HELP ENSURE PROPER PLANNING FOR TRANSITION. ONCE NOTIFIED OF DESIRE FOR TERMINATION OF THE ARRANGEMENT THE PIHP/CMHSP WILL ENSURE THAT HEALTH AND WELFARE OF BENEFICIARY AND SERVICES NEEDS ARE MET THROUGH A COMBINATION OF WORKING WITH THE BENEFICIARY'S CURRENT STAFF OR BACK UP STAFF AND COORDINATION WITH THE CONTRACTED PROVIDER WHO WILL BE TAKING OVER SERVICE DELIVERY. CMHSP WILL ENSURE THE DAY OF THE HANDOFF SERVICES ARE SET UP CORRECTLY AND THE TRANSITION WAS SUCCESSFUL, TYPICALLY THROUGH IN PERSON OVERSIGHT BY THE SUPPORT COORDINATOR AT TIME OF TRANSITION.
THE SELF-DIRECTED SERVICES TECHNICAL REQUIREMENTS AND SELF-DIRECTION TECHNICAL REQUIREMENTS IMPLEMENTATION GUIDE SETS FORTH THE PROCEDURE FOR THE PIHP/CMHSP TO FOLLOW. THE SELF DETERMINATION AGREEMENT DEFINES THE RESPONSIBILITIES OF THE PARTIES REGARDING PARTICIPATION AND IS IN EFFECT UNTIL IT IS CHANGED OR ENDED, AS OUTLINED IN THE PIHP CONTRACT AND RELATED POLICIES REGARDING SELF-DIRECTION. EITHER PARTY CAN INITIATE A CHANGE OR END TO THE AGREEMENT BY PROVIDING WRITTEN NOTICE TO THE OTHER PARTY. THE PIHP/CMHSP MUST RESPOND TO ANY SUCH NOTICE WITHIN SEVEN (7) WORKING DAYS.

Upon termination of participant direction, the PIHP/CMHSP has an obligation for assuring that all identified service needs are met by providers. SAFEGUARDS FOR ASSURING SERVICE CONTINUITY BEYOND PLANNING AND PREPARATION ARE ENFORCED THROUGH CONTRACT REQUIREMENTS.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A PIHP or CMHSP may involuntarily terminate participant direction when the health and welfare of the beneficiary is in jeopardy, or other serious problems are resulting from the beneficiary's failure in directing services and supports. The Self-Directed Services Technical Requirements and Self-Direction Technical Requirement Implementation Guide sets forth the procedure for the PIHP to follow and provides direction. As outlined in the PIHP contract and related policies regarding self-direction, prior to terminating an agreement, and unless it is not feasible, the PIHP shall participate in problem resolution and inform the participant of the issues that have led to the decision to consider altering or discontinuing the arrangement in writing. ANY BUDGET REDUCTION OR TERMINATION MUST BE TREATED AS A "REDUCTION, SUSPENSION, OR TERMINATION" FOR PURPOSES OF INTERNAL APPEAL AND FAIR HEARING RULES (INCLUDING ADVANCE NOTICE THROUGH AN ADVERSE BENEFIT DETERMINATION).

The person-centered planning process will be used to address the issues, with termination being the option of choice if other mutually agreeable solutions cannot be found. In any instance of discontinuation or alteration of an arrangement, THE BENEFICIARY MUST BE NOTIFIED IN WRITING 14 CALENDAR DAYS BEFORE THE PCP MEETING AND the local grievance procedure process will be used to address and resolve the issues, as outlined in the PIHP contract and related policies regarding self-direction. The decision of the PIHP to terminate participant direction does not alter the services and supports identified in the individual plan of service. In that event, the PIHP has an obligation to take over responsibility for providing those services through its network of qualified providers. The PIHP CMHSP will ensure that health and welfare of beneficiary and services needs are met through a combination of working with the beneficiary's current staff or back up staff and coordination with the contracted provider who will be taking over service delivery. CMHSP will ensure the day of the handoff services are set up correctly and the transition was successful, typically through in person oversight by the support coordinator at time of transition.

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		2144
Year 2		2305
Year 3		2478
Year 4		2664
Year 5		2864

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected

staff:

In the Agency Supported Self-Direction model, participants serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (described in this document as ASSD provider) IS CONTRACTED WITH THE PIHP/CMHSP AND serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing workers compensation insurance). In the Supported Self-Direction model, participants may get help with selecting their workers (for example, the ASSD provider may have a pool of workers available for consideration by participants). The ASSD provider may also provide back-up workers when the participants regular worker is not available. Like traditional staffing agencies, the ASSD provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that participants directly employing workers may not be able to provide. The Agency Supported Self-Direction model is also an important option for participants who do not want to directly employ workers or who want to transition into direct employment. A FMS PROVIDER AGENCY WOULD ONLY BE USED IN ASSD ARRANGEMENTS IF THE BENEFICIARY WERE ALSO USING BUDGET AUTHORITY AND ACTING AS AN EMPLOYER AGENT OR WHEN USING A PURCHASE OF SERVICES AGREEMENT TO HIRE AN ASSD PROVIDER WHO IS NOT IN THE PIHP IMPANELED NETWORK

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

☑ **Refer staff to agency for hiring (co-employer)**

☑ **Select staff from worker registry**

☑ **Hire staff common law employer**

☑ **Verify staff qualifications**

☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The financial management service provider is responsible for conducting criminal history reviews for directly employed personal assistance providers. The cost is built into their monthly fee.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Not applicable. Same as c-2-a.

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☑ **Determine staff wages and benefits subject to state limits**

☑ **Schedule staff**

☑ **Orient and instruct staff in duties**

☑ **Supervise staff**

☑ **Evaluate staff performance**

☑ **Verify time worked by staff and approve time sheets**

☑ **Discharge staff (common law employer)**

☑ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☑ **Reallocate funds among services included in the budget**

☑ **Determine the amount paid for services within the state's established limits**

☑ **Substitute service providers**

☑ **Schedule the provision of services**

☑ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☑ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☑ **Identify service providers and refer for provider enrollment**

☑ **Authorize payment for waiver goods and services**

☑ **Review and approve provider invoices for services rendered**

☑ **Other**

Specify:

1. Execute and terminate purchase of service agreements with clinical service providers.
2. Authorize payment for contracted clinical service providers

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An individual budget is a robust reflection of how the person has chosen to allocate their funds to purchase the supports and services of their choice that they need to meet the goals in their plan. They should be invested in their plan and budget to allow them to achieve their vision of living an inclusive, productive, autonomous life. Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP). Both the beneficiary and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the beneficiary. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the beneficiary is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process.

A simple methodology using reliable cost estimating information is used to develop the budget. This is called the estimated cost of services (ECOS) which is included in every IPOS. Each budget is the sum of the units of service multiplied by the period covered, multiplied by the rate for the service as agreed upon by the participant and authorized through the IPOS. The state does not set a uniform rate for each service. This formula allows each self-directed employer to set a wage for their employees within the limits of their budget. Typically, when an existing person-centered service plan is transitioned to an arrangement which supports self-determination, the overall budget is not more than the costs of delivering the services under the previous traditional service plan.

This Estimated Cost of Services (ECOS)is consistently applied to each plan for every beneficiary and gives the beneficiary a baseline for their budget. Through the person-centered planning process, the beneficiary and their team decides how they will utilize the medically necessary dollars to purchase their unique services and supports. The estimated budget in this planning period is based off of assessed need of each beneficiary and cost is set at the rate that would have been used based on the beneficiary's acuity level for each medically necessary service. The details of this constant approach is publicly available can be found in the Self-Direction Technical Requirement Implementation Guide which is published on the MDHHS website. The ECOS is the total amount of funds used for the current services and that total of funds that must be available for the person's use for planning and developing their individual budget. (must be robust enough to have resources to follow FLSA laws, cover employer agent and other admin)

Michigan uses a retrospective zero-based method for developing an individual budget. The amount of the individual budget is determined by costing out the services and supports in the IPOS, after a IPOS that meets the beneficiaries needs and goals has been developed. In the IPOS, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the beneficiary to exercise flexibility (usually one year).

Once the IPOS is developed, the amount of funding needed to obtain the identified services and supports is determined collectively by the beneficiary, the mental health agency (PIHP or designee), and others participating in the PCP process. This will allow the services planned and purchased to be directed and controlled by the beneficiary and/or their authorized representative, including the amount, duration, scope, provider, and location of such services.

This process involves costing out the services and supports using the rates for providers chosen by the beneficiary and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Workers Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS.

Beneficiaries must use a Financial Management Service if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a beneficiary chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a Financial Management Service be used.

Financial Management Service (FMS) is a waiver service and is available to any beneficiary using a self-determination arrangement. Each PIHP develops a contract with the Financial Management service to provide financial management services (FMS) and sets the rate and costs for the services. Actual costs for the FMS will vary depending on the beneficiary's needs and usage of FMS, as well as the negotiated rate between the PIHP and financial management service.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Materials provided by the PIHP include written information on the development of the individual budget. During the planning process, a beneficiary is to be provided clear information and explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the beneficiary during individual budget implementation. Found in the Estimated Costs of Services, which is a contractual requirement for every IPOS whether the beneficiary chooses to self-direct their services or not.

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the IPOS, using the PCP process, or is determined as applied to a pre-existing, sufficient IPOS, using the PCP process. Budget authorization is contingent upon the beneficiary and the PIHP entity reaching agreement on the amount of the budget and on the methods that will, or may, be applied by the beneficiary to implement the plan and the individual budget. IF THE PERSON-CENTERED PLANNING PROCESS DOES NOT RESULT IN AN AGREED BUDGET, THE PIHP/CMHSP SHALL SET THE BUDGET AND, PENDING RESOLUTION THROUGH ANY INTERNAL APPEAL AND FAIR HEARING THAT THE PARTICIPANT MAY PURSUE, THE BUDGET SHALL BE SET EQUAL TO THE IMMEDIATELY PRECEDING BUDGET.

The budget will be provided to the beneficiary in written form, as an attachment to the Self- Determination Agreement that outlines the expectations and obligations of the participant and the PIHP. The beneficiary's plan is also attached to the agreement.

The beneficiary's supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the beneficiary) are expected to provide assistance to the beneficiary in understanding the budget and how to utilize it. In situations where the beneficiary also has an independent supports broker; the broker will assist the beneficiary to understand and apply the budget. The beneficiary may seek major adjustment to the individual budget that would mean an increase in medically necessary support by requesting this from their supports coordinator or other chosen qualified provider. The supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the beneficiary) will be expected to assist the beneficiary to convene a meeting including the beneficiary's chosen family members and allies, and to assure facilitation of a PCP process to review and reconsider the budget. A change in the budget is not effective unless the beneficiary and the PIHP CMHSP have agreed to the changes. The CMHSP must inform beneficiaries as to how, when, and what kind of changes they can make to their individual budget without support coordinator approval and when such changes require approval. The mental health agency (PIHP or designee) must provide the beneficiary with information on how to request a Medicaid fair hearing when the beneficiary's Medicaid- funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of the budget adjustment. Information on how to request a fair hearing is attached to every IPOS and a copy of that IPOS is distributed to each beneficiary as mandated.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The Materials provided by the PIHP include written information on the development of the individual budget. During the planning process, a beneficiary is to be provided clear information and explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the beneficiary during individual budget implementation. Found in the Estimated Costs of Services.

IF THE BENEFICIARY IS OPTING TO MAKE CHANGES THAT DO NOT AFFECT THE OVERALL LIMIT OF THE BUDGET AND WILL BE ESSENTIALLY MOVING FUNDS FROM ONE LINE ITEM TO ANOTHER IN ORDER TO ADJUST AMOUNT, SCOPE, DURATION OF SUPPORTS OUTLINED IN THE BUDGET, THE BENEFICIARY CAN WORK WITH THEIR FMS ENTITY TO MAKE AND DOCUMENT THOSE CHANGES. THE SUPPORTS COORDINATOR, SUPPORTS COORDINATOR ASSISTANT, OR INDEPENDENT SUPPORTS BROKER (OR OTHER QUALIFIED PROVIDER SELECTED BY THE BENEFICIARY) WILL BE NOTIFIED AND EXPECTED TO MAKE ADJUSTMENTS TO THE IPOS FOR CLARIFICATION ON THE NEW EXPECTED AMOUNT, SCOPE AND DURATION IN THE BUDGET FOR PURPOSES OF OVERSIGHT THAT SERVICES WERE RENDERED AS INDICATED IN THE PLAN.

UNLESS AN ADJUSTMENT DEVIATES FROM THE GOALS AND OBJECTIVES IN THE BENEFICIARY'S IPOS, THE BENEFICIARY IS NOT REQUIRED TO OBTAIN PERMISSION FROM THE MENTAL HEALTH AGENCY (PIHP OR DESIGNEE) OR PROVIDE ADVANCE NOTIFICATION OF AN INTENDED ADJUSTMENT. THE IPOS MUST BE WRITTEN IN A WAY THAT CONTEMPLATES AND PLANS FOR THE MANNER IN WHICH THE PARTICIPANT MAY USE THE SERVICES AND SUPPORTS. AMOUNTS, SCOPES AND DURATIONS ARE WRITTEN IN LENGTH OF TIME THAT MAKES FLEXIBILITY POSSIBLE (A MONTH OR A QUARTER). SERVICES AND SUPPORTS THAT ARE SIMILAR AND MAY BE SUBSTITUTED FOR ONE ANOTHER SHOULD BE IDENTIFIED AS WELL AS SERVICES AND SUPPORTS FOR WHICH THERE IS NO SUBSTITUTION. ADJUSTMENTS IN THIS MANNER SHOULD BE COMMUNICATED TO THE MENTAL HEALTH AGENCY (PIHP OR DESIGNEE) IN A TIMELY MANNER.

SOMETIMES, A PARTICIPANT WANTS TO MAKE AN ADJUSTMENT THAT FUNDAMENTALLY ALTERS THE IPOS (FOR EXAMPLE, SUBSTITUTING ONE SERVICE FOR ANOTHER SERVICE THAT IS NOT SIMILAR, FORGOING SERVICES AND SUPPORTS, OR USING SERVICES AND SUPPORTS NOT AUTHORIZED). IF THE ADJUSTMENT DOES NOT SERVE TO ACCOMPLISH THE DIRECTION AND INTENT OF THE PERSON'S IPOS, THEN THE IPOS MUST BE APPROPRIATELY MODIFIED BEFORE THE ADJUSTMENT MAY BE MADE AND MUST BE DONE THROUGH THE PCP PROCESS THEN AGREED UPON THROUGH THAT PROCESS BY BOTH THE BENEFICIARY AND THE CMHSP.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Beneficiaries must use a financial management provider if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs.

The funds in an individual budget are transferred to the financial management provider, which handles payment for services and supports in the IPOS upon receipt of invoices and timesheets authorized by the beneficiary. The FMS provides both the beneficiary and the mental health agency (PIHP or designee) a monthly report of expenditures and flags expenditures that are over or under the expected amount by ten percent or more. This report is the central mechanism for monitoring implementation of the budget. Over- or underutilization identified in the report can be addressed by the supports coordinator (or other chosen qualified provider) and beneficiary informally or through the PCP process.

The supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) is responsible for assisting the beneficiary in implementing the individual budget and arrangements, including understanding the budget report. A beneficiary can use an independent supports broker to assist him or her in implementing and monitoring the IPOS and budget. When a beneficiary uses an independent supports broker, the supports coordinator (other qualified provider selected by the beneficiary) has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the authorization and monitoring the IPOS and individual budget cannot be delegated to an Independent Supports Broker by the PIHP or designee.

Through the FMS, the supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact they have with the beneficiary, the supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The State has established a grievance system that is compliant with 42 CFR 431 Subpart F through contract agreement with each PIHP. The Grievance and Appeal Technical Requirement is within the MDHHS/PIHP contract.

The notice of ANY action to the beneficiary or his/her legal representative must be PROVIDED in writing and must meet the requirements of 42 CFR 438.10 (i.e., "...manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

The PIHPs are required to provide timely and adequate notice of any Adverse Benefit Determination. The content of the notice must meet the following requirement:
- Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;
- Description of Adverse Benefit Determination;
- The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;
- Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);
- Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;
- Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;
- Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";
- Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and
- An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

The Adverse Benefit Determination Notice allows for the opportunity for internal review with the PIHP prior to the beneficiary requesting a State Fair Hearing in some situations.
- The PIHP provides this Notice to the beneficiary when denying a requested service that is not already in place. This is effective on the decision date.
- The Adverse Benefit Determination Notice is also used when terminating, suspending, reducing a service that is in place, and is provided to the beneficiary 10 days before the effective date, unless there is an exception.
- As long as a written request is received before the effective date, services remain in place until the Notice of Resolution is sent to the beneficiary. If a determination is being made or action is being taken based upon suspect of fraud, the Adverse Benefit Determination Notice is sent to the beneficiary but may only be sent 5 days before the effective date.

Appeal Resolution Notice:
- The notice of resolution must include the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:

i. Right to request a state fair hearing, and how to do so;
ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

THE REQUEST FOR FAIR HEARING IS PROVIDED WHEN A PERSON RECEIVES AN ADVERSE BENEFIT DETERMINATION WHICH INCLUDES THE ENROLLEES RIGHT TO REQUEST AN APPEAL. THIS INCLUDES THE ENROLLEE'S RIGHT TO REQUEST AN APPEAL OF THE PIHPS ADVERSE BENEFIT DETERMINATION, INCLUDING INFORMATION ON EXHAUSTING THE PIHPS LEVEL OF APPEAL, AND THE RIGHT TO REQUEST A STATE FAIR HEARING THEREAFTER. (42 CFR 438.404(B)(3)

THE PIHPS MUST MAINTAIN RECORDS OF ADVERSE ACTIONS AND REQUESTS FOR MEDICAID FAIR HEARING. THE RECORD MUST BE ACCURATELY MAINTAINED IN A MANNER ACCESSIBLE TO THE STATE AND AVAILABLE UPON REQUEST TO CMS.

If a beneficiary not enrolled in the HSW requests to apply for the HSW, the beneficiary must be given the choice of home and community-based waiver services as an alternative to the level of care provided in an ICF/IID by the PIHP. Evidence that the PIHP offered this choice to the beneficiary is documented in the HSW eligibility certification form. If the PIHP does not offer the choice between home and community-based services instead of the level of care offered by an ICF/IID, the PIHP must give adequate notice to the beneficiary or legal representative (if applicable) per the process described above.

In unique circumstances where the PIHP submits HSW applications to MDHHS for review, if the beneficiary is determined to not meet eligibility requirements for the HSW, an adequate notice is sent to the beneficiary and legal representative (if applicable) by the MDHHS Federal Compliance Section Manager. This notice follows the process described above.

Once a beneficiary has enrolled in the HSW, the beneficiary may receive adequate or advance notice, depending on the decision related to their HSW or other Medicaid mental health services.

Upon completion of the development of the individual plan of services (IPOS) through the person-centered planning process, the beneficiary or his legal representative is provided adequate notice of action at the time of the signing that he or she may file a request for a fair hearing if he or she subsequently disagrees with the scope, duration or intensity of authorized services. Adequate notice of action is also provided when there is a decision by the PIHP to deny or limit authorization for services requested. Notice is provided to the beneficiary or his/her legal representative on the same date as the action takes effect. CMHSP PROVIDER WILL EXPLAIN THAT SERVICES WILL CONTINUE AS LISTED IN THE IPOS UNTIL RULING ON THE APPEAL.

PIHP policies and procedures vary as to upon whom the responsibility is placed to notify beneficiaries or their legal representatives of an adverse action, e.g. Utilization Management, Customer Services, person designated in the plan of service as responsible for assuring that committed services/supports are delivered. (MDHHS Admin. Rule 330.7199)

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy. The MDHHS Federal Compliance Section also monitors Fair Hearing Requests and Decisions by the Tribunal for HSW beneficiaries and takes action with the PIHP when necessary to assure HSW services are provided as specified in policy.

All notices of action which include information on the opportunity to request a State fair hearing are maintained in appropriate PIHP administrative files and a copy in the beneficiary's record.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ● **Yes. The state operates an additional dispute resolution process**

• **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 State has established a grievance and appeals system that is compliant with 42 CFR 431 Subpart F through contract agreement with each PIHP. The Appeal and Grievance Resolution Processes Technical Requirement of the MDHHS/PIHP Contract is applicable to all the PIHPs, the CMHSPs, and their provider networks.
Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, (denial, termination, suspension or reduction of a service), and those challenging anything else, (beneficiary's dissatisfaction with service, quality of care or services provided or aspects of interpersonal relationships between a service provider and the beneficiary). A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

MEDICAID ENROLLEES ALSO HAVE RIGHTS AND DISPUTE RESOLUTION PROTECTIONS UNDER AUTHORITY OF THE MICHIGAN MENTAL HEALTH CODE, THROUGH A RECIPIENT RIGHTS COMPLAINTS OR A MEDICAL SECOND OPINION. BENEFICIARIES ARE NOTIFIED IN WRITING THAT THE DISPUTE RESOLUTION IS NOT A PRE-REQUISITE OR SUBSTITUTE FOR A FAIR HEARING.

BENEFICIARY APPEALS: Beneficiary Appeals are initiated by notice of an adverse benefit determination (ABD) (action). Upon receipt of an ABD notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:
* The Enrollee has 60 calendar days from the date of the notice of ABD to request an Appeal.
* The Enrollee may request an Appeal either orally or in writing. Oral inquiries seeking to Appeal an ABD are treated as appeals.
* If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: The enrollee files the request for an appeal timely within 60 calendar days from the date on the ABD Notice; the enrollee files for continuation of benefits timely on or before the latter of within 10 calendar days of the PIHP sending the notice of ABD; or the intended effective date of the proposed ABD; and the period covered by the original authorization request has not expired.

PIHP Responsibilities when the Enrollee Requests Appeals-The PIHP must:
* Provide any reasonable assistance to complete forms and take other procedural steps. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capability.
* Acknowledge receipt of an expedited Appeal within 72 hours of receipt. The PIHP must acknowledge receipt of each standard Appeal within 5 business days.
* Maintain a record of appeals for review by the State as part of its quality strategy.
* Ensure that the individual(s) who make the decisions on appeals are individuals: Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; who when deciding an Appeal that involves either involves clinical issues, or a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; and consider all comments, documents, records, and other information submitted by the enrollee and/or their representative without regard to whether such information was submitted or considered in the initial ABD.
* Provide the enrollee a reasonable opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. The PIHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals.
* Provide the enrollee and the enrollee's representative the enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP, in connection with the Appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
* Provide opportunity to include as parties to the Appeal the enrollee and the enrollee's representative or the legal representative of a deceased enrollee's estate.
* Provide the enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one. The enrollee can request a State Fair Hearing only after receiving notice that the PIHP is upholding the ABD. In the case of a PIHP that fails to adhere to the notice and timing requirements of 30 days, the enrollee is deemed to have exhausted the PIHP's appeals process. The enrollee may initiate a State fair hearing.

Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution: The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days from PIHP receipt of the Appeal.
2. Expedited Appeal Resolution:
a)Each PIHP must establish and maintain an expedited review process for appeals when the PIHP determines (for a request from the enrollee) or the provider indicates (in making a request on the enrollee's behalf or supporting the enrollee's request) that the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
b)The PIHP may not take punitive action against a provider who requests an expedited resolution or supports the enrollee's Appeal.
c)If a request for expedited resolution of an appeal is denied, the PIHP must: Transfer the Appeal to the timeframe for standard resolution, make reasonable efforts to give the enrollee prompt oral notice of the denial if the PIHP extends the timeframes not at the request of the enrollee, within two (2) calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision and resolve the Appeal as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days.
d)If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72 hours after the PIHP receives the request for expedited resolution of the Appeal.

Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to 14 calendar days if the enrollee requests or if the PIHP shows (to the satisfaction of the State, upon its request) that there is a need for additional information, and how the delay is in the enrollee's interest.

Appeal Resolution Notice: The PIHP must provide Enrollees with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's right to request a State Fair Hearing, and how to do so and the right to request to receive benefits while the State Fair Hearing is pending, and how to make the request; and the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's ABD.

BENEFICIARY GRIEVANCES: Medicaid beneficiaries have the right to a local grievance process for issues that are not "actions". Generally, the enrollee must file a Grievance with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances. A Grievance may be filed at any time by the enrollee, guardian, or parent of a minor child, or the enrollee's authorized representative. For each grievance filed by a beneficiary, the PIHP is required to:
1.Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers with adequate TTY/TTD and interpreter capability; acknowledge receipt of the Grievance within 5 business days; Maintain a record of grievances for review by the State as part of its quality strategy; Ensure that the individual(s) who make the decisions on the Grievance are individuals: Who were neither involved in any previous level review or decision-making, nor a subordinate of any such individual, who are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease; for a grievance regarding denial of expedited resolution of an appeal and/or a grievance that involves clinical issues and who consider all comments, documents, records, and other information submitted by the enrollee and/or the enrollee's representative without regard to whether such information was submitted or considered previously.

Timing of Grievance Resolution: Provide the enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP received the Grievance.
Extension of Timeframes: The PIHP may extend the Grievance resolution and notice timeframe by up to 14 calendar days if the enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the enrollee's interest. If the PIHP extends resolution/notice timeframes not at the request of the enrollee, it must make reasonable efforts to give the enrollee prompt oral notice of the delay and within 2 calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if they disagree with the decision.

STATE FAIR HEARING PROCESS:
*Federal regulations provide the enrollee the right to an impartial review by a State-level Administrative Law Judge (a

State Fair Hearing), of an action (denial, termination, suspension or reduction) of a local agency or its agent, after receiving notice that the PIHP is upholding an ABD after Appeal and when the PIHP fails to adhere to the notice and timing requirements for resolution of appeals.
*The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if the following conditions of the review are met: Must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing; must be independent of both the State and the PIHP, must be offered without any cost to the enrollee, must not extend any of the required timeframes and must not disrupt the continuation of benefits.
*The PIHP may not limit or interfere with the enrollee's freedom to make a request for a State Fair Hearing.
*The enrollee is given no more than 120 calendar days from the date of the applicable Notice of Resolution to file a request for a State Fair Hearing.
*The PIHP is required to continue benefits if the conditions described in Section VII - Medicaid Services Continuation or Reinstatement are satisfied and for the duration described therein.
*If the enrollee's services were reduced, terminated, or suspended without advance notice, the PIHP must reinstate services to the level before the ABD.
*The parties to the State Fair Hearing include the enrollee and the enrollee's representative, or the representative of a deceased enrollee's estate, and the PIHP.
*Expedited hearings are available.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Do not complete this item.

• **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).

Do not complete this item.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b*

through e)

No. This Appendix does not apply *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The MDHHS requires reporting on the following critical incidents, immediate reportable events, sentinel event analysis and allegations of abuse, exploitation, and neglect. All critical incident and immediate reportable events are reported through the Customer Relationship Management (CRM) system. Allegations of abuse, exploitation, and neglect are reported to the local Community Mental Health Services Program (CMHSP) Office of Recipient Rights (ORR).

CRITICAL INCIDENT REPORTING AND IMMEDIATE REPORTABLE EVENTS:
MDHHS oversees all critical incidents and immediate reportable events through the CRM to monitor this reporting as incidents/events are submitted for trends, outliers and issues. Review includes requesting and reviewing of required remediations which provide individual (if applicable) and/or systemic responses to prevent reoccurrence. The system allows for MDHHS to ensure the PIHP's process for reporting these incidents and events is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would require submission of a corrective action plan by the PIHP. The corrective action plan effectiveness submitted by the PIHP will be reviewed by MDHHS during ongoing reviews of critical incident reports and event reporting when submitted.
MDHHS requires the PIHPs and CMHSPs to report critical incident data and related information into the CRM as a measure of how well the PIHP/CMHSP and its contracted providers monitor the care of vulnerable service recipients, including HSW beneficiary. The Critical Incident Reporting System (CIRS) through the CRM enables MDHHS to receive data on beneficiaries within specified timeframes, depending on the type of event. People enrolled under the HSW are a reportable population in the CIRS. CIRS requires the PIHP to report the following events to MDHHS: suicide, non-suicide death, emergency medical treatment due to injury, falls or medication error, hospitalization due to injury, falls or medication error, and arrest of beneficiary. Timeframes for reporting the five specified events in the CIRS are:

Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

Non-suicide death: Due within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the CMHSP attempts to determine whether the death was due to suicide. In that case the submission is due within 30 days of the end of the month in which CMHSP determined the death was not due to suicide.

Emergency medical treatment due to injury, fall or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Hospitalization due to injury, fall or medication error: Due within 60 days after the end of the month in which the emergency medical treatment began.

Arrest: Due within 60 days after the end of the month in which the arrest occurred.

Definitions for Critical Incident Reporting System (CIRS):
- Suicide: A Beneficiary's death shall be reported as a suicide when either one of the following two conditions exists:

1. The CMHSP serving the beneficiary determines, through its death review process, that the beneficiary's death was a suicide, or
2. The official death report (i.e., coroner's report) indicates that the beneficiary's death was a suicide

- Non-suicide Death: Any death, for beneficiary in the reportable population, that was not otherwise reported as a suicide. The reportable population includes any HSW beneficiary.
- Emergency Medical Treatment due to Injury, Fall or Medication Error: Situations where an injury to a beneficiary, injury due to a beneficiary fall or a medication error results in face-to-face emergency treatment being provided by medical staff. Any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms should be reported, provided the treatment was sought due to an injury, fall or medication error.
- Hospitalization due to injury, fall or medication error: Situations where an injury to a beneficiary, injury due to a beneficiary fall or a medication error results in hospitalization of the beneficiary. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.
- Fall: Defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.
- Medication error: Defined as a situation where a mistake is made when a beneficiary takes prescribed medication (i.e., incorrect dosage taken, prescription medication taken that is not prescribed, medication taken at wrong time, medication

used improperly), or a situation where non-prescription medication is taken improperly.
- Injury: Defined as bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body. Examples of injuries include bruises (except those due to illness), contusions, muscle sprains, and broken bones.
- Arrest: Situations where a beneficiary is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a consumer is transported for the purpose of receiving emergency mental health services, or situations where a consumer is held in protective custody, are not considered to be an arrest.

The MDHHS/PIHP contract requires the PIHP to report immediate reportable events into the CRM when any of the following egregious events occur:
- Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation (report within 48 hours of death or PIHP's notification of death),
- relocation of a beneficiary's placement due to licensing suspension or revocation (report to MDHHS within five business days),
- conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of his or her job duties or responsibilities (report to MDHHS within five business days)
- an occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours (report to MDHHS and
- Critical Incidents which may be newsworthy or represent a community crisis must be reported immediately.

SENTINEL EVENT

A Sentinel Event is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The PIHP or delegated provider must prepare and file critical incident reports that include the following components:
i. Provider determination whether critical incidents are sentinel events.
ii. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.
iii. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.

OFFICE OF RECIPIENT RIGHTS

Allegations of abuse (including exploitation) and neglect are reported to the local CMHSP ORR through the incident report forms and/or recipient rights complaint forms. Any person employed by the MDHHS, each CMHSP, each licensed hospital, and each service provider under contract with the department, such as a PIHP or any of its subcontractors, has a duty to report any suspected abuse and/or neglect to the local ORR. Michigan law and rules require the mandatory reporting of recipient rights complaints in a timely manner to the CMHSP ORR. CMHSP policies further specify that reports of rights violations are immediately reported to their ORR. Reporting may be done in writing or by phone or by other means of communication, such as fax. If the ORR substantiates a rights violation related to abuse, including exploitation or neglect, the ORR makes a recommendation for remediation to the CMHSP director. the local CMHSP ORR reporting to other state agencies, such as the Department of Licensing and Regulatory Affairs, Child Protective Services (CPS), or Adult Protective Services (APS), and involvement by local law enforcement.

Certain situations involving suspected abuse and neglect must also be reported to law enforcement, CPS or APS. The Michigan Mental Health Code requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) "immediately shall make or cause to be made, by telephone or otherwise, an oral report of the suspected criminal abuse to the law enforcement agency for the county or city in which the criminal abuse is suspected to have occurred or to the state police. Within 72 hours after making the oral report, the reporting individual shall file a written report with the law enforcement agency to which the oral report was made, and with the chief

administrator of the facility or agency responsible for the recipient (330.1723)." Michigan's Child Protection Law requires the following with regard to reporting suspected child abuse or neglect to MDHHS CPS for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) "immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this Act (722.623)." Michigan's Social Welfare Act requires the following with regard to reporting suspected criminal abuse to law enforcement for mandatory reporters, which would include employees or contractors of the mental health system providing waiver services: (the reporter) "who suspects or has reasonable cause to believe that an adult has been abused, neglected, or exploited shall make immediately, by telephone or otherwise, an oral report to the county department of social services of the county in which the abuse, neglect, or exploitation is suspected of having or believed to have occurred. After making the oral report, the reporting person may file a written report with the county department [400.11(a)]."

OTHERS: Other agencies, such as law enforcement, protective services, or licensing, may receive reports of allegations of abuse, neglect, and exploitation. Where beneficiaries live in licensed settings, Michigan law and rules (for example, R 400.14311 for small and large licensed AFC homes) require licensee to complete an Incident/Accident Report; a copy of which is forwarded to the CMHSP ORR, CMHSP and responsible agency) which would assure the immediate health and welfare of the beneficiary, as well as that of any other mental health recipients in the home.
The report includes the following:
1. A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:
a) The death of a beneficiary.
b) Any accident or illness that requires hospitalization.
c) Incidents that involve any of the following:
i. Displays of serious hostility
ii. Hospitalization.
iii. Attempts at self-inflicted harm or harm to others.
iv. Instances of destruction to property.
d) Incidents that involve the arrest or conviction of a beneficiary as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
2. An immediate investigation of the cause of an accident or incident that involves a beneficiary, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
3. If a resident is absent without notice, the licensee or direct care staff shall do both of the following:
a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.
b) Contact the local police authority.
4. A licensee shall make a reasonable attempt to locate the resident through means other than those specified in subrule (3) of this rule.
5. A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.
6. An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
a) The name of the person who was involved in the accident or incident.
b) The date, hour, place, and cause of the accident or incident.
c) The effect of the accident or incident on the person who was involved and the care given.
d) The name of the individuals who were notified and the time of notification.
e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.
f) The corrective measures that were taken to prevent the accident or incident from happening again.
7. A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

DEFINITIONS:
Definitions of Abuse and Neglect (MDHHS Administrative Rule 330.7001):

Abuse is divided into three categories, Abuse Class I, Abuse Class II and Abuse Class III. Neglect is also divided into three categories, Neglect Class I and Neglect Class II and Neglect Class III. Abuse Class I and II and Neglect Class I and II are required to be reported to MDHHS on a semi-annual basis as each involves some level of physical or emotional harm to the recipient or involves sexual abuse.

Abuse class I means a nonaccidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to the death, or sexual abuse of, or serious physical harm to a recipient. "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Sexual abuse means any of the following:
i. Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
ii. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
iii. Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
Sexual contact means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or ratification, done for a sexual purpose, or in asexual manner for any of the following:
i. Revenge.
ii. To inflict humiliation.
iii. Out of anger.

Sexual penetration means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Abuse class II means any of the following:
i. A non-accidental act or provocation of another to act by an employee, volunteer, or agent of a provider that caused or contributed to nonserious physical harm to a recipient.
ii. The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm.
iii. Any action or provocation of another to act by an employee, volunteer, or agent of a provider that causes or contributes to emotional harm to a recipient.
iv. An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient.
v. Exploitation of a recipient by an employee, volunteer, or agent of a provider.

Emotional harm means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Exploitation means an action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Nonserious physical harm means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.
Neglect class I means either of the following:
i. Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law and/or rules, policies, guidelines, written directives, procedures, or individual plan of service and causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient.

ii. The failure to report apparent or suspected abuse Class I or neglect Class I of a recipient.

Neglect class II" means either of the following:
i. Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service and that cause or contribute to non serious physical harm or emotional harm to a recipient.
ii. The failure to report apparent or suspected abuse Class II or neglect Class II of a recipient.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

EVERY RECIPIENT OF PUBLIC MENTAL HEALTH SERVICES IN MICHIGAN AND HIS/HER LEGAL REPRESENTATIVES RECEIVE A BOOKLET DEVELOPED BY MDHHS ENTITLED "YOUR RIGHTS WHEN RECEIVING MENTAL HEALTH SERVICES IN MICHIGAN" AT THE TIME OF ADMISSION INTO SERVICES FROM SCREENING/INTAKE PROVIDER AND THEN ANNUALLY THEREAFTER BY THE SUPPORTS COORDINATOR DURING THE IPOS MEETING. THIS BOOKLET PROVIDES INFORMATION CONCERNING PROTECTIONS FROM ABUSE, NEGLECT, AND EXPLOITATION, INCLUDING HOW TO NOTIFY AUTHORITIES. THE INFORMATION IS ALSO PROVIDED AS NEEDED OR REQUESTED BY THE BENEFICIARY OR THEIR FAMILIES. THIS IS IN ACCORDANCE WITH SECTION 330.1706 OF THE CODE: "... APPLICANTS FOR AND RECIPIENTS OF MENTAL HEALTH SERVICES AND IN THE CASE OF MINORS, THE APPLICANT'S OR RECIPIENT'S PARENT OR GUARDIAN, SHALL BE NOTIFIED BY THE PROVIDERS OF THOSE SERVICES OF THE RIGHTS GUARANTEED BY THIS CHAPTER. NOTICE SHALL BE ACCOMPLISHED BY PROVIDING AN ACCURATE SUMMARY OF THIS CHAPTER AND CHAPTER 7A TO THE APPLICANT OR RECIPIENT AT THE TIME SERVICES ARE FIRST REQUESTED AND BY HAVING A COMPLETE COPY OF THIS CHAPTER AND CHAPTER 7A READILY AVAILABLE FOR REVIEW BY APPLICANTS AND RECIPIENTS. FROM RULE 330.7011: A NOTE DESCRIBING THE EXPLANATION OF THE MATERIALS AND WHO PROVIDED THE EXPLANATION SHALL BE ENTERED IN THE RECIPIENT'S RECORD. THE REQUIRED NOTIFICATION/EXPLANATION INCLUDES EXPLICIT, DETAILED COVERAGE OF THE CODE MANDATED PROTECTIONS FROM ABUSE, NEGLECT, AND EXPLOITATION, AND THE HOW BENEFICIARIES (AND/OR FAMILIES OR LEGAL REPRESENTATIVES, AS APPROPRIATE) CAN NOTIFY APPROPRIATE AUTHORITIES OR ENTITIES WHEN THE BENEFICIARIES MAY HAVE EXPERIENCED ABUSE, NEGLECT OR EXPLOITATION. BENEFICIARIES AND THEIR FAMILIES CAN ALSO CONTACT THE CMHSP ORR AND CUSTOMER SERVICES DEPARTMENT, THEIR LOCAL LEGAL AUTHORITIES (POLICE) OR LARA (IF THEY RESIDE IN A SPECIALIZED RESIDENTIAL SETTING) DIRECTLY IF THEY HAVE EXPERIENCED ABUSE, NEGLECT OR EXPLOITATION.

Chapter 7 of the Michigan Mental Health Code also requires that every CMHSP ORR must assure that all program sites, whether directly operated or through contract with the CMHSP, have rights booklets available in public areas for beneficiaries, guardians, care-givers, etc. The booklet describes the various rights afforded the beneficiary under the U.S. Constitution, Michigan Constitution, the Michigan Mental Health Code and MDHHS Administrative Rules as well as contact information for the CMHSP ORR if the recipient, legal representative, or anyone on behalf of the recipient feels that the recipient's rights have been violated, including the right to be free from abuse or neglect.

The MDHHS/PIHP contract requires that each PIHP must have a Customer Services Unit that provides information about mental health and other services, how to access the various rights processes, and assists people who use alternate means of communication or have Limited English Proficiency (LEP). For example, the Customer Services Unit staff may read the Rights booklet to a beneficiary. The Customer Services Unit may also, upon request of the beneficiary, assist with contacting the local Office of Recipient Rights for assistance with an issue related to abuse, neglect or exploitation.

The ORR also houses a Training Unit to ensure that recipient rights initiatives are consistently implemented statewide. In addition to training staff of CMHSPs and their contracted agencies, other persons working in the recipient rights field (advocacy agency staff, for example) can access training because their roles are essential to preserving and protecting service recipients' rights. CMHSP ORRs conduct rights informational sessions for beneficiaries, family members, advocates and interested others. Additionally, the MDHHS holds annual Recipient Rights, Beneficiary, and Home and Community Based Waiver Conferences, all of which include beneficiaries and/or their families. These conferences provided Recipient Rights training that describe beneficiary rights and the complaint resolution and appeal process.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical incidents may be investigated by the CMHSP ORR, the PIHP, the CMHSP, as well as by law enforcement or other state agencies LIKE LICENSING AND REGULATORY AFFAIRS (LARA) as applicable depending on the nature of the incident. WHEN A BENEFICIARY DEATH OCCURS IN A CONGREGATE HOMES, A CONGREGATE FACILITY LICENSEE OR ADMINISTRATOR SHALL NOTIFY IMMEDIATELY THE RESIDENT'S PHYSICIAN, THE NEXT OF KIN OR LEGAL GUARDIAN AND THE PERSON OR AGENCY RESPONSIBLE FOR PLACING AND MAINTAINING THE RESIDENT IN THE CONGREGATE FACILITY. STATUTES APPLICABLE TO THE REPORTING OF SUDDEN OR UNEXPECTED DEATH SHALL BE OBSERVED. IF THE BENEFICIARY HAS A GUARDIAN OR FAMILY MEMBER, THEY SHOULD BE INFORMED WITHIN 48 HOURS OF THE INCIDENT OR WHEN INFORMED OF THE INCIDENT.
EVENT REPORTING: The MDHHS/PIHP Contract, following event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service. The written report will include beneficiary information, date, time and place of death (if in a foster care setting, the foster care license #), final determination of cause of death (from coroner's report or autopsy), summary of conditions (physical, emotional) and treatment or interventions preceding death, any quality improvement actions taken as a result of an unexpected or preventable death, and the PIHP's plan for monitoring to assure any quality improvement actions are implemented.

SENTINEL EVENT: The PIHP, or its CMHSP affiliate with delegated responsibility, must review the incident to determine if it meets the criteria and definitions for sentinel events and are related to practice of care. Depending on the type of incident, it may also be required to report on the CIRS to MDHHS. The MDHHS/PIHP contract, requires that each PIHP's Quality Assessment Performance Improvement Plan (QAPIP) addresses sentinel events. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

All unexpected deaths (deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect) of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:
- Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
- Involvement of medical personnel in the mortality reviews
- Documentation of the mortality review process, findings, and recommendations
- Use of mortality information to address quality of care
- Aggregation of mortality data over time to identify possible trends.

Per the MDHHS/PIHP Contract, physical management, permitted for intervention in emergencies only, is considered a critical incident that must manage and reported according to the Quality Assessment and Performance Improvement Plan (QAPIP) standards. Physical management is defined as "a technique used by staff to restrict the movement of a beneficiary by direct physical contact in order to prevent the beneficiary from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the beneficiary or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan." Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. The MDHHS requires PIHPs to report, review, investigate and act upon sentinel events for those persons listed. An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements" (JCAHO, 1998). A root cause analysis or investigation is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance". Following completion of a root cause analysis or investigation, the PIHP must develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated.

CRITICAL INCIDENT REPORTING SYSTEM in the CRM: The CIRS in the CRM requires the PIHPS and CMHSPs to report the following events to MDHHS: suicide, non-suicide death, emergency medical treatment due to injury, fall or

medication error, hospitalization due to injury, fall or medication error, and arrest of beneficiary. PIHPs/CMHSPs will submit reports directly (through Application Programming Interface) into the CRM. Incidents reported in the CRM would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. Additionally, some of the incidents reported in the CRM such as a death or injury, could result in a criminal investigation or referral to Child or Adult Protective Services. MDHHS staff review incidents that are considered priorities as they are reported, such as certain types of deaths (suicide and accidental deaths for example) and injuries (related to the use of restrictive interventions or medication errors for example). This allows MDHHS to request more immediate corrective action and response to these priority incidents. PIHPs have 30 days to respond to remediations generated by priority incidents reported or those requested by MDHHS staff. The CRM allows for MDHHS to monitor for trends, outliers, and issues more closely and in real time. In addition, the CRM allows for CMHSPs/PIHPs to indicate whether CPS, APS LARA AFC Licensing or ORR investigations have been opened to investigate the incident. CMHSPs/PIHPs are also able to identify those incidents reported which have been determined a Sentinel Event. Section G-1-b of this application defines incidents and identifies timelines for reporting to the state.

OFFICE OF RECIPIENT RIGHTS: Events involving suspected or apparent abuse and neglect are reviewed by the CMHSP ORR to determine if there may have been a rights violation. Section 330.1778 provides: The local office [of Recipient Rights] within the CMHSP affiliates of the PIHPs shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies as described in subsection (5), the office shall complete the investigation not later than 90 days after it receives the rights complaint WHICH IS CALLED THE REPORT OF INVESTIGATIVE FINDINGS (RIF). Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. ORR sends letter to the beneficiary within five days acknowledging receipt of the complaint and then provides written updates TO THE BENEFICIARY every 30 days until the investigation is completed. The Executive Director of the CMHSP then issues a written Summary Report WITHIN 10 DAYS OF THE OF THE COMPLETION OF THE RIF including the conclusion of the office of recipient rights and the action or plan of action to remedy a violation to the complainant, BENEFICIARY if different than complainant and guardian of the recipient if one has been appointed. The report includes notice of appeal rights. Information gathered from investigations is reviewed for trends and becomes a focus of the on-site visitation conducted by MDHHS to CMHSPs. Aggregate data are shared with MDHHS, the Quality Improvement Council (QIC) and Federal Compliance staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

OTHER: In the event of a reported incident of a child or adult, MDHHS - CPS or APS is responsible for investigating allegations of abuse, neglect or exploitation and ensuring beneficiary safety. The CMHSP ORR is responsible for investigating rights violations. The Department of Licensing and Regulatory Affairs is responsible for investigating licensing rule violations. Law enforcement may also be conducting an investigation related to possible criminal activity in conjunction with the above. Local DHS offices must have signed agreements with their respective CMHSP boards and AFC licensing to cover roles and responsibilities for handling APS investigations in mental health settings. The protocol for joint operating agreements and the model agreements for this coordination for reporting, investigating, and sharing information are in the Adult Services Manual (DHS-ASM 256).

If, during a MDHHS site visit, the site review team member identifies an issue that places a beneficiary in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

EVENT NOTIFICATION: Events requiring "immediate notification", as identified in G-1-b, are considered egregious events and are reviewed through the MDHHS internal process. If it is determined that the event is for an HSW beneficiary, immediate follow up by MDHHS staff will occur.

CRITICAL INCIDENT REPORTING SYSTEM in the CRM: PIHPs/CMHSPs will submit reports directly (through Application Programming Interface) into the CRM. Incidents reported in the CRM would also be investigated by the CMHSP ORR if the incidents were believed to be the result of suspected rights violation due to abuse or neglect. MDHHS staff review incidents that are considered priorities as they are reported, such as certain types of deaths (suicide and accidental deaths for example) and injuries (related to the use of restrictive interventions or medication errors for example). The system allows for MDHHS to ensure the PIHP's process for reporting these incidents and events is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would require submission of a corrective action plan by the PIHP. PIHPs have 30 days to respond to remediations generated by priority incidents reported or those requested by MDHHS staff. The CRM allows for MDHHS to monitor for trends, outliers, and issues more closely and in real time. MDHHS will monitor incidents for HSW beneficiaries, establish a baseline "penetration" rate and set targets for reductions in the rate of critical incidents that will result from systems improvement strategies from systems improvement strategies identified in Appendix H and oversight of critical incidents.

OFFICE OF RECIPIENT RIGHTS: On a semi-annual basis, local CMHSP ORRs report to MDHHS the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDHHS include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local Rights office, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semi- annual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population, including HSW beneficiaries. An annual report is produced by the State ORR and submitted to community partners and the Legislature.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

- ◉ **The state does not permit or prohibits the use of restraints**

  Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

MDHHS requires that any beneficiary receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict a beneficiary's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, as outlined in the MDHHS/PIHP contract.

Each rights office established by the Mental Health Code, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Licensing and Regulatory Affairs (LARA)is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows:

R 400.14308 Resident behavior interventions prohibitions.

(2)A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(a)Use any form of punishment.
(b)Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
(c)Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
(d)Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS Site Review Team, which reviews agency policy for consistency with State law during annual visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with beneficiaries or staff.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

- **The state does not permit or prohibits the use of restrictive interventions**

  Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

MDHHS REQUIRES THAT ANY BENEFICIARY RECEIVING PUBLIC MENTAL HEALTH SERVICES HAS THE RIGHT TO BE FREE FROM ANY FORM OF RESTRAINT OR SECLUSION USED AS A MEANS OF COERCION, DISCIPLINE, CONVENIENCE OR RETALIATION, AS REQUIRED BY THE 1997 FEDERAL BALANCED BUDGET ACT AT 42 CFR 438.100 AND SECTIONS 740 AND 742 OF THE MICHIGAN MENTAL HEALTH CODE. MICHIGAN'S MENTAL HEALTH CODE PROHIBITS THE USE OF RESTRAINT OR SECLUSION IN ANY SERVICE SITE EXCEPT A HOSPITAL, CENTER OR CHILD CARING INSTITUTIONS. (MCL 330.1740, MCL 330.1742) THE MICHIGAN MEDICAID MANUAL PROHIBITS PLACEMENT OF A WAIVER BENEFICIARY INTO A CHILD CARING INSTITUTION. THE MICHIGAN MENTAL HEALTH CODE DEFINES RESTRAINT AS THE USE OF A PHYSICAL DEVICE TO RESTRICT A BENEFICIARY'S MOVEMENT BUT DOES NOT INCLUDE AN ANATOMICAL SUPPORT OR PROTECTIVE DEVICE. (MCL 330.1700[I]). IT DEFINES SECLUSION AS THE TEMPORARY PLACEMENT OF A RECIPIENT IN A ROOM ALONE WHERE EGRESS IS PREVENTED BY ANY MEANS. (MCL 330.1700[J]).

THE USE OF RESTRAINT AND SECLUSION IS ADDRESSED IN THE MDHHS STANDARDS FOR BEHAVIOR TREATMENT PLAN REVIEW COMMITTEES, AS OUTLINED IN THE MDHHS/PIHP CONTRACT. IT IS ALSO MONITORED BY THE MDHHS SITE REVIEW TEAM TO ENSURE RESTRAINTS OR SECLUSION IS NOT BEING ADMINISTERED ON BENEFICIARIES.

THE USE OF RESTRICTIVE OR INTRUSIVE INTERVENTIONS IS ALLOWED BUT ONLY UNDER CIRCUMSTANCES WHERE ANY BEHAVIOR TREATMENT PLAN THAT PROPOSES THE USE OF RESTRICTIVE OR INTRUSIVE INTERVENTIONS IS APPROVED BY THE BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE (BTPRC). RESTRICTIVE OR INTRUSIVE INTERVENTIONS WILL ONLY BE USED AS A LAST RESORT WHEN THERE IS DOCUMENTATION THAT NEITHER POSITIVE BEHAVIOR SUPPORTS, NOR OTHER KINDS OF LESS RESTRICTIVE INTERVENTIONS WERE SUCCESSFUL. RESTRICTIONS THAT INCLUDE AVERSIVE TECHNIQUES, PHYSICAL MANAGEMENT, SECLUSION, OR INVOLVEMENT OF LAW ENFORCEMENT IN NON-EMERGENT SITUATIONS OR RESTRAINT ARE NOT PERMITTED AND WILL NOT BE APPROVED BY BTPRC. EACH CMHSP SHALL HAVE A BTPRC TO REVIEW AND APPROVE OR DISAPPROVE ANY PLANS THAT PROPOSE TO USE RESTRICTIVE OR INTRUSIVE INTERVENTIONS.

THE PCP PROCESS USED IN THE DEVELOPMENT OF A WRITTEN IPOS WILL IDENTIFY WHEN A BEHAVIOR TREATMENT PLAN NEEDS TO BE DEVELOPED AND WHERE THERE IS DOCUMENTATION THAT FUNCTIONAL BEHAVIORAL ASSESSMENTS HAVE BEEN CONDUCTED TO RULE OUT PHYSICAL, MEDICAL, OR ENVIRONMENTAL CAUSES OF THE TARGET BEHAVIOR, AND THAT THERE HAVE BEEN UNSUCCESSFUL ATTEMPTS, USING POSITIVE BEHAVIORAL SUPPORTS AND INTERVENTIONS, TO PREVENT OR ADDRESS THE TARGET BEHAVIOR. THE IPOS WILL INCLUDE THE RESTRICTIVE INTERVENTIONS

BEHAVIOR TREATMENT PLANS MUST BE DEVELOPED THROUGH THE PCP PROCESS AND WRITTEN SPECIAL CONSENT MUST BE GIVEN BY THE INDIVIDUAL, OR HIS/HER GUARDIAN ON HIS/HER BEHALF IF ONE HAS BEEN APPOINTED, OR THE PARENT WITH LEGAL CUSTODY OF A MINOR PRIOR TO THE IMPLEMENTATION OF THE BEHAVIOR TREATMENT PLAN THAT INCLUDES INTRUSIVE OR RESTRICTIVE INTERVENTIONS.

RESTRICTIVE TECHNIQUES ARE THOSE TECHNIQUES WHICH, WHEN IMPLEMENTED, WILL RESULT IN THE LIMITATION OF THE INDIVIDUAL'S RIGHTS AS SPECIFIED IN THE MICHIGAN MENTAL HEALTH CODE. EXAMPLES OF SUCH TECHNIQUES AS LIMITING OR PROHIBITING COMMUNICATION WITH OTHERS WHEN THAT COMMUNICATION WOULD BE HARMFUL TO THE INDIVIDUAL; ACCESS TO PERSONAL PROPERTY WHEN THAT ACCESS WOULD BE HARMFUL TO THE INDIVIDUAL; OR ANY LIMITATION OF THE FREEDOM OF MOVEMENT OF AN INDIVIDUAL FOR BEHAVIOR CONTROL PURPOSES. USE OF ANY RESTRICTIVE TECHNIQUES FOR BEHAVIOR CONTROL PURPOSES REQUIRES THE REVIEW AND APPROVAL OF THE BTPRC.

INTRUSIVE TECHNIQUES ARE THOSE TECHNIQUES THAT ENCROACH UPON THE BODILY

INTEGRITY OR THE PERSONAL SPACE OF THE INDIVIDUAL FOR THE PURPOSE OF ACHIEVING MANAGEMENT OR CONTROL OF A SERIOUSLY AGGRESSIVE, SELF-INJURIOUS, OR OTHER BEHAVIOR THAT PLACES THE INDIVIDUAL OR OTHERS AT RISK OF PHYSICAL HARM. EXAMPLES OF SUCH TECHNIQUES INCLUDE THE USE OF A MEDICATION OR DRUG WHEN IT IS USED TO MANAGE OR CONTROL AN INDIVIDUAL'S BEHAVIOR OR RESTRICT THE INDIVIDUAL'S FREEDOM OF MOVEMENT AND IS NOT A STANDARD TREATMENT OR DOSAGE FOR THE INDIVIDUAL'S CONDITION. USE OF INTRUSIVE TECHNIQUES AS DEFINED REQUIRES THE REVIEW AND APPROVAL BY THE COMMITTEE.

DOCUMENT THAT ANY MODIFICATIONS OF THE HCB SETTINGS REQUIREMENTS ARE BASED UPON A SPECIFIC ASSESSED HEALTH AND SAFETY NEED AND JUSTIFIED IN THE PERSON-CENTERED SERVICE PLAN;

- IDENTIFY THE SPECIFIC ASSESSED NEED(S);
- DOCUMENT THE POSITIVE INTERVENTIONS AND SUPPORTS USED PREVIOUSLY;
- DOCUMENT LESS INTRUSIVE METHODS THAT WERE TRIED AND DID NOT WORK, INCLUDING HOW AND WHY THEY DID NOT WORK;
- INCLUDE A CLEAR DESCRIPTION OF THE CONDITION THAT IS DIRECTLY PROPORTIONATE TO THE ASSESSED NEED; INCLUDE REGULAR COLLECTION AND REVIEW OF DATA TO MEASURE THE EFFECTIVENESS OF THE MODIFICATION; INCLUDE ESTABLISHED TIME LIMITS FOR PERIODIC REVIEW OF THE MODIFICATION;
- INCLUDE INFORMED CONSENT OF THE INDIVIDUAL; AND
- INCLUDE ASSURANCES THAT THE MODIFICATIONS WILL CAUSE NO HARM TO THE INDIVIDUAL.

ALL RESTRICTIVE OR INTRUSIVE INTERVENTIONS MUST BE REVIEWED ON A QUARTERLY BASIS AND RECORDED IN A PROGRESS NOTE. IF THE REVIEW DETERMINES THAT CHANGES ARE REQUIRED, THIS WILL BE REFLECTED IN AN AMENDMENT TO THE IPOS.

ALL STAFF WORKING WITH THE BENEFICIARY WILL BE TRAINED ON ALL RESTRICTIVE OR INTRUSIVE INTERVENTIONS PRIOR TO WORKING WITH THE BENEFICIARY AND AT A MINIMUM ANNUALLY OR AS CHANGES OCCUR.

ON A QUARTERLY BASIS, THE PIHPS TRACK AND ANALYZE THE USE OF ALL PHYSICAL MANAGEMENT AND INVOLVEMENT OF LAW ENFORCEMENT FOR EMERGENCIES, AND THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES BY EACH BENEFICIARY RECEIVING THE INTERVENTION, THIS INCLUDES UNAUTHORIZED USE OF RESTRICTIVE INTERVENTIONS. THE DATA ON THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES MUST BE EVALUATED BY THE PIHP'S QAPIP OR THE CMHSP'S QIP AND BE AVAILABLE FOR MDHHS REVIEW.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

AS STATED IN G-2 B-I THE USE OF RESTRAINT AND SECLUSION IS ADDRESSED IN THE MDHHS STANDARDS FOR BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE WHICH IS AN ATTACHED POLICY IN THE MDHHS/PIHP CONTRACT. THE PIHP AND AFFILIATED CMHSP OR CONTRACTED PROVIDERS IS RESPONSIBLE TO OVER THE USE OF RESTRICTIVE PROCEDURES TO ENSURE THAT THE STATE'S SAFEGUARDS ARE FOLLOWED. THE ALSO INCLUDE ADHERENCE TO THE
MICHIGAN MENTAL HEALTH CODE 330.1726 AND MDHHS ADMINISTRATIVE RULES 330.7199.

ON A QUARTERLY BASIS, THE PIHPS TRACK AND ANALYZE THE USE OF ALL PHYSICAL MANAGEMENT AND INVOLVEMENT OF LAW ENFORCEMENT FOR EMERGENCIES, AND THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES BY EACH BENEFICIARY RECEIVING THE INTERVENTION, AS WELL AS:

- DATES AND NUMBERS OF INTERVENTIONS USED.
- THE SETTINGS (E.G., BENEFICIARY'S HOME OR WORK) WHERE BEHAVIORS AND INTERVENTIONS OCCURRED
- OBSERVATIONS ABOUT ANY EVENTS, SETTINGS, OR FACTORS THAT MAY HAVE TRIGGERED THE BEHAVIOR.
- BEHAVIORS THAT INITIATED THE TECHNIQUES.
- DOCUMENTATION OF THE ANALYSIS PERFORMED TO DETERMINE THE CAUSE OF THE BEHAVIORS THAT PRECIPITATED THE INTERVENTION.
- DESCRIPTION OF POSITIVE BEHAVIORAL SUPPORTS USED. 7.BEHAVIORS THAT RESULTED IN TERMINATION OF THE INTERVENTIONS.
- LENGTH OF TIME OF EACH INTERVENTION.
- STAFF DEVELOPMENT AND TRAINING AND SUPERVISORY GUIDANCE TO REDUCE THE USE OF THESE INTERVENTIONS.
- REVIEW AND MODIFICATION OR DEVELOPMENT, IF NEEDED, OF THE BENEFICIARY'S BEHAVIOR PLAN.

THIS PROCESS HELPS DETECT UNAUTHORIZED USE, OVER-USE OR INAPPROPRIATE OR INEFFECTIVE USE OF THE RESTRICTIVE PROCEDURE. THE DATA ON THE USE OF INTRUSIVE AND RESTRICTIVE TECHNIQUES MUST BE EVALUATED BY THE PIHP'S QAPIP OR THE CMHSP'S QIP, AND BE AVAILABLE FOR MDHHS REVIEW. PHYSICAL MANAGEMENT PERMITTED FOR INTERVENTION IN EMERGENCIES ONLY, ARE CONSIDERED CRITICAL INCIDENTS THAT MUST BE MANAGED AND REPORTED ACCORDING TO THE QAPIP STANDARDS. ANY INJURY OR DEATH THAT OCCURS FROM THE USE OF ANY BEHAVIOR INTERVENTION IS CONSIDERED A SENTINEL EVENT.

THE MDHHS SITE REVIEW TEAM TO ENSURE RESTRAINTS OR SECLUSION IS NOT BEING ADMINISTERED ON BENEFICIARIES DURING THEIR BIENNIAL SITE REVIEW WHICH WILL BE MOVING TO ANNUAL IN FISCAL YEAR 2026.

THE USE OF PHYSICAL MANAGEMENT WOULD ALSO GENERATE AN CRITICAL INCIDENT REPORT THAT IS REVIEWED BY THE CMHSP ORR. IF AFTER INVESTIGATION BY THE CMHSP ORR, IT IS DETERMINED THAT STAFF USED PHYSICAL MANAGEMENT (1) WHEN THERE IS NOT AN IMMINENT RISK OF HARM TO THE RECIPIENT OR OTHERS, (2) IF THE PHYSICAL MANAGEMENT USED IS NOT IN COMPLIANCE WITH THE TECHNIQUES APPROVED BY THE CMHSP, (3) THE PHYSICAL MANAGEMENT USED IS NOT IN COMPLIANCE WITH THE EMERGENCY INTERVENTIONS AUTHORIZED IN THE RECIPIENT'S INDIVIDUAL PLAN OF SERVICE, AND/OR
(4) PHYSICAL MANAGEMENT IS USED WHEN OTHER LESSER RESTRICTIVE MEASURES WERE POSSIBLE BUT NOT ATTEMPTED IMMEDIATELY BEFORE THE USE OF PHYSICAL MANAGEMENT, THE CMHSP ORR WILL SUBSTANTIATE ABUSE CLASS II USE OF UNREASONABLE FORCE, AGAINST THE STAFF. THE MICHIGAN MENTAL HEALTH CODE MANDATES THAT DISCIPLINARY ACTION FOR ANY SUBSTANTIATED ABUSE OR NEGLECT.

THE CRITICAL INCIDENT REPORTS IN THE CRM CAPTURES INDIVIDUALLY IDENTIFIABLE

INCIDENTS WHERE PHYSICAL MANAGEMENT IS USED THAT CAUSES EMERGENCY MEDICAL TREATMENT OR HOSPITALIZATION. IN THESE REPORTING SITUATIONS, MDHHS REQUIRES THE PIHP TO PROVIDE A REMEDIATION TO PREVENT OR REDUCE THE LIKELIHOOD OF REOCCURRENCE. MDHHS MONITORS AND REVIEWS THE CIR REPORTING SYSTEM TO COMPLETES MONTHLY REPORTS ON THIS DATA TO ANALYZE ISSUES, TRENDS AND PATTERNS TO INFORM POTENTIAL QUALITY IMPROVEMENT ACTIVITIES.

THE PIHPS ARE RESPONSIBLE TO MONITOR THE CRITICAL INCIDENT REPORTING FROM THEIR CMHSPS OR CONTRACTED PROVIDERS. THE PIHP QUALITY MANAGEMENT STAFF REVIEWS ALL CIRS SUBMITTED. PIHPS ARE REQUIRED TO PROVIDE ANY TECHNICAL GUIDANCE, TRAINING OR CORRECTIVE ACTION OF THEIR CMHSPS OR CONTRACTED PROVIDERS IN ORDER TO PREVENT OR REDUCE THE LIKELIHOOD OR REOCCURRENCE.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- (●) **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

MDHHS requires that any beneficiary receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's beneficiary's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]).

In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, the Medicaid Specialty Supports and Services Program contract between MDHHS and the PIHPs; the Agreement Between MDHHS and CMHSPs For Managed Mental Health Supports and Services.

Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually.

The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows:

R 400.14308 Resident behavior interventions prohibitions.

(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:
(a) Use any form of punishment.
(b) Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement.
(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.

Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS Site Review Team, which reviews agency policy for consistency with State law during annual visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during interviews with beneficiaries or staff.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ● **Yes. This Appendix applies** *(complete the remaining items)*

- **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.

THE REQUIREMENT TO REPORT MEDICATION ERRORS IS THE FIRST STEP IN IDENTIFYING HARMFUL PRACTICES. THIS REQUIREMENT IS IDENTIFIED IN THE PIHP CONTRACT WITH MDHHS.

The PIHPs and their affiliated CMHSPs OR CONTRACT PROVIDERS have ongoing responsibility for "second line" management and monitoring of beneficiary medication regimens ["first line" management and monitoring is the responsibility of the prescribing medical professional]. The beneficiary's individual plan of services and supports must contain complete information about their medications regimen [i.e., what each medication is for; frequency and dosage; signs and symptoms suggesting/requiring attention, etc.]. These details and any other monitoring recommendations from the prescribing professional are shared with the members of the beneficiary's planning team [as authorized by the beneficiary], and all provider staff with medication administration/self-administration assistance/monitoring responsibilities. This helps all within the beneficiary's planning/service/support network to know when to request a formal medication review outside those scheduled within the plan. Supports coordinators' monitoring of beneficiaries includes general monitoring of the effectiveness of the beneficiary's medication regimens. These monitoring activities are conducted through case record review, face-to-face meetings with beneficiaries, and discussion with direct care and other staff as appropriate. Supports coordinators average one face-to-face visit per month with HSW beneficiaries.

The PIHP AND THEIR AFFILIATED CMHSPS OR CONTRACT PROVIDERS medications monitoring procedure, called a Medication Review WHICH IS ANOTHER AVENUE TO IDENTIFY POTENTIAL HARMFUL PRACTICES, is by definition the evaluation and monitoring of medications, their effects, and the need for continuing or changing the medication regimen WHICH MAY BE PERFORMED BY A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications. The frequency of regular medication reviews must be specified in the beneficiary's individual plan of services and supports, BUT THE AVERAGE for those beneficiaries who required them is approximately once per quarter.

Michigan's Department of Licensing and Regulatory Affairs licenses and certifies Adult Foster Care that provide specialized residential services. A significant number of HSW beneficiaries reside in this type of setting. THE LICENSING RULES DICTATE THE REQUIREMENTS FOR MEDICATION, INCLUDING STORAGE, STAFF TRAINING, ADMINISTRATION, AND THE REPORTING OF MEDICATION ERRORS. DHS LICENSING INSPECTIONS OCCUR EVERY TWO YEARS, AS WELL AS CONDUCTING SPECIAL INVESTIGATIONS WHEN NEEDED.

THE CRITICAL INCIDENT REPORTS IN THE CRM CAPTURES INDIVIDUALLY IDENTIFIABLE MEDICATION ERRORS FOR HSW BENEFICIARIES THAT REQUIRED EMERGENCY MEDICAL TREATMENT OR HOSPITALIZATION. WHEN A HOSPITALIZATION OR EMERGENCY MEDICAL TREATMENT DUE TO MEDICATION ERROR IS REPORTED FOR A HSW BENEFICIARY, MDHHS STAFF FOLLOW-UP WITH THE PIHP INCLUDING REQUIRING A PLAN OF CORRECTION FROM THE PIHP/CMHSP TO ENSURE THE CAUSE OF THE MEDICATION ERROR IS IDENTIFIED AND REMEDIATED. MDHHS MONITORS AND RESPONDS TO CIR REPORTING SYSTEM COMPLETES MONTHLY REPORTS ON THIS DATA TO ANALYZE ISSUES, TRENDS AND PATTERNS TO INFORM POTENTIAL QUALITY IMPROVEMENT ACTIVITIES.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

In addition to MDHHS requiring the PIHPs, CMHSPs OR CONTRACTED PROVIDERS OVERSIGHT outlined in G-3-a.i, the state's specialized residential certification rule R330.1806(2)(e) requires that "all staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas. . .proper precautions and procedures for administering prescriptive and non-prescriptive medications." In addition to the regular Medication Reviews by the PIHPs, CMHSPs OR CONTRACTED PROVIDERS medical professionals specified in the plan, supports coordinators and others are trained to spot signs and symptoms of potentially harmful practices and can request an unscheduled Med Review and an IPOS meeting to address any confirmed issues OR HARMFUL PRACTICES.

The CRITICAL INCIDENT REPORTS IN THE CRM captures individually identifiable medication errors for HSW beneficiaries that required emergency medical treatment or hospitalization. When a hospitalization or emergency medical treatment due to medication error is reported for a HSW beneficiary, MDHHS staff follow-up with the PIHP including requiring a plan of correction from the PIHP/CMHSP to ensure the cause of the medication error is identified and remediated. MDHHS MONITORS AND RESPONDS TO CIR REPORTING SYSTEM COMPLETES MONTHLY REPORTS ON THIS DATA TO ANALYZE ISSUES, TRENDS AND PATTERNS TO INFORM POTENTIAL QUALITY IMPROVEMENT ACTIVITIES.

During annual MDHHS site reviews of the PIHPs, MDHHS staff on the site review team evaluate residential service provider compliance with staff training and incident reporting requirements, as well as the PIHP's monitoring and follow-up of medication errors. In addition, the site reviews evaluate compliance with Behavior Treatment Plan Committee. If a potentially harmful practice is identified at any level, the PIHP works with the provider to correct the practice. If a residential provider does not cooperate toward correction, the PIHP may file a complaint with MDHHS, and per rule R330.1804: (2) Upon receipt of a complaint regarding the provision of specialized program services, the department shall conduct a review within 30 days to determine whether these rules have been violated. The department shall issue a written report of its findings and provide a copy to the department of human services, the complainant, the facility, and the placing agency; (3) The department shall issue a complaint against a facility if rule violations warrant; (4) Failure of the licensee to fully cooperate with the department in connection with inspections and investigations is a ground for the denial, suspension, or revocation of, or refusing to renew, a facility's certification. Non-cooperation from non-residential providers can result in the PIHP revoking their contracts/removing them from their waiver services provider panel

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **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).

PIHPS, CMHSPS OR CONTRACTED PROVIDERS WHICH ENCOMPASSES ANY PROVIDER WHO ADMINISTERS MEDICATIONS OR ASSIST THE BENEFICIARY WITH MEDICATIONS MUST BE TRAINED ON MEDICATION ADMINISTRATION PRIOR TO WORKING WITH THE BENEFICIARY WHO CANNOT SELF-ADMINISTER AND EVERY THREE YEARS THEREAFTER. ADDITIONAL TRAINING MAY BE REQUIRED IN RESPONSE TO REMEDIAL ACTION REQUESTS. TRAINING IS PROVIDED BY A REGISTERED NURSE AND OVERSIGHT OF PERSONNEL IS THE RESPONSIBILITY OF THE EMPLOYER/PROVIDER. ADDITIONAL OVERSIGHT MAY BE PROVIDED BY THE CASE MANAGER OR OTHER MEDICAL PROFESSIONALS TREATING THE BENEFICIARY LIKE A REGISTERED NURSE, PSYCHOLOGIST OR PSYCHIATRIST.

ANY PROVIDER WHO ADMINISTERS MEDICATIONS OR ASSIST THE BENEFICIARY WITH MEDICATIONS MUST ENSURE THEY ADHERE TO THE FOLLOWING REQUIREMENTS:
The Michigan Administrative Rule 330.7158 addresses medication administration:
(1) A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
(2) A provider shall assure that medication use conforms to federal standards and the standards of the medical community.
(3) A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
(4) A provider shall review the administration of a psychotropic medication periodically as set forth in the recipients individual plan of service and based upon the recipients clinical status.
(5) If an individual cannot administer his or her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
(6) A provider shall record the administration of all medication in the recipient's clinical record.
(7) A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient's clinical record.

- **Medication Error Reporting.** *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

● **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

PIHPS, CMHSPS OR CONTRACTED PROVIDERS WHICH ENCOMPASSES ANY PROVIDER WHO ADMINISTER MEDICATIONS OR ASSIST THE BENEFICIARY WITH MEDICATIONS ARE responsible for medication administration are required to record medication errors as noted in G-3-c.i above in Administrative Rule 330.7158 (7). PIHPs must report certain medication errors to MDHHS per the MDHHS/PIHP and CMHSP contracts.

PROVIDERS WHO ADMINISTER MEDICATIONS OR ASSIST THE BENEFICIARY WITH MEDICATIONS MUST RECORD VIA A CRITICAL INCIDENT REPORT THE FOLLOWING- Medication errors: wrong medication; wrong dosage; double dosage; or missed dosage which resulted in death or loss of limb or function or the risk thereof. AFC licensing rules require that incident reports be completed when a medication error occurs. Refusals would be documented on the medication administration sheet maintained by the provider. It does not include instances in which beneficiaries have refused medication. CRITICAL INCIDENT REPORTS OF THIS NATURE ARE REPORTED TO LARA (IF THE INDIVIDUAL LIVES IN AFC, THE PIHP, THE CMHSP OR CONTRACTED PROVIDER AND GUARDIAN/FAMILY IF APPLICABLE.

Sentinel event reporting requirements require the PIHPs and CMHSPs to report medication errors to the MDHHS-MHSA when those medication errors result in an actual or potential loss of life, limb, or function, or pose a risk of psychological harm.

The Critical Incident Reporting System WITHIN THE CRM provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CRM is the source for information related to medication errors that are critical incidents.

- **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.

ONGOING MONITORING WILL BE DONE BY MDHHS AND THE PIHPS.

MDHHS will monitor the critical incidents related to medication errors through the CRITICAL INCIDENTS REPORTING (CIR) IN THE CRM REGARDING MEDICATION ERRORS to monitor for trends and outliers. MDHHS may require the PIHP to receive additional technical assistance or training as a result of CIRS data. THE PIHPS MAY BE REQUIRED TO PROVIDE SYSTEMIC REMEDIATIONS FOR TRENDS OR PATTERNS THAT RESULT IN THE NEED FOR CORRECTIVE ACTION TO SUPPORT IMPROVEMENT IN MEDICATION ADMINISTRATION. MDHHS MONITORS CIR REPORTING SYSTEM COMPLETES MONTHLY REPORTS ON THIS DATA TO ANALYZE ISSUES, TRENDS AND PATTERNS TO INFORM POTENTIAL QUALITY IMPROVEMENT ACTIVITIES.

DURING MDHHS SITE REVIEWS, SITE REVIEW STAFF VERIFIES THE PIHP'S PROCESS FOR CRITICAL INCIDENT REPORTING IS BEING IMPLEMENTED PER MDHHS POLICY.

MDHHS HAS CREATED A CIR LEADS WORKGROUP WHICH INCLUDES QUALITY MANAGEMENT STAFF FROM THE PIHPS. CMHSPS AND CONTRACT PROVIDERS. THE CIR LEADS WORKGROUP MEETS MONTHLY TO REVIEW CURRENT CIR REQUIREMENTS AND IDENTIFY STRATEGIES TO IMPROVE THE REPORTING PROCESS, ELIMINATE INEFFICIENCIES AND DEVELOP STRATEGIES TO IMPROVE QUALITY AND REDUCE CRITICAL INCIDENT REPORTING.

- PIHPS ARE RESPONSIBLE TO MONITOR THE CRITICAL INCIDENT REPORTING FROM THEIR CMHSPS OR CONTRACTED PROVIDERS. THE PIHP QUALITY MANAGEMENT STAFF REVIEWS ALL CIRS SUBMITTED TO MONITOR FOR TRENDS OR PATTERNS. PIHPS WILL ADDRESS TRENDS AND PATTERNS THROUGH TECHNICAL GUIDANCE, TRAINING OR CORRECTIVE ACTION OF THEIR CMHSPS OR CONTRACTED PROVIDERS IN ORDER TO PREVENT OR REDUCE THE LIKELIHOOD OR REOCCURRENCE.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

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 substantiated abuse and neglect events reported for waiver beneficiaries that are remediated. Numerator: All substantiated abuse and neglect events reported for waiver beneficiaries. Denominator: Number of substantiated abuse and neglect events reported for waiver beneficiaries that are remediated.

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of beneficiaries who have received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of beneficiaries who received information and education in the prior year. Denominator: Number of beneficiaries sampled.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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 critical incidents reported outside the timeframe as required by MDHHS/PIHP contract. Numerator: Number of critical incidents reported for HSW beneficiaries not within the timeframe as required by MDHHS/PIHP contract. Denominator: All critical incidents reported for HSW beneficiaries within the timeframe.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDHHS Office of Recipient Rights

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The 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 BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT DUE TO MEDICATION ERROR WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS TYPE. NUMERATOR: NUMBER OF BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT NOT DUE TO MEDICATION ERROR. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF EMERGENCY MEDICAL TREATMENT FOR MEDICATION ERRORS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
NUMBER AND PERCENT OF BENEFICIARIES REQUIRING HOSPITALIZATION DUE TO MEDICATION ERROR WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS TYPE. NUMERATOR: NUMBER OF BENEFICIARIES NOT REQUIRING HOSPITALIZATION DUE TO MEDICATION ERROR. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF HOSPITALIZATION FOR MEDICATION ERRORS.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of beneficiaries ("B") req. hospitalization ("H") d/t injury related to the use of physical mgt. (PM) where remediation was completed to avoid future incidents ("I") of this type. Numer.: # of "B" requiring "H" d/t injury related to the use of PM

where remediation was completed to avoid future "I" of this type. Denom.: All "B" with reported "I" of "H" for injury related to the use of PM.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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:

Performance Measure:
NUMBER AND PERCENTAGE OF BENEFICIARIES REQUIRING EMERGENCY MEDICAL TREATMENT DUE TO A FALL (ACCIDENTAL, PURPOSEFUL OR MEDICAL) WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS TYPE. NUMERATOR: NUMBER OF BENEFICIARIES NOT REQUIRING EMERGENCY MEDICAL TREATMENT DUE TO A FALL. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF EMERGENCY MEDICAL TREATMENT FOR A FALL.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
NUMBER AND PERCENTAGE OF BENEFICIARIES REQUIRING HOSPITALIZATION DUE TO A FALL (ACCIDENTAL, PURPOSEFUL OR MEDICAL) WHERE REMEDIATION WAS COMPLETED TO AVOID FUTURE INCIDENTS OF THIS TYPE. NUMERATOR: NUMBER OF BENEFICIARIES NOT REQUIRING HOSPITALIZATION DUE TO A FALL. DENOMINATOR: ALL BENEFICIARIES WITH REPORTED INCIDENTS OF HOSPITALIZATION FOR A FALL.

Data Source (Select one):

Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **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 records being reviewed where the Behavior Treatment Plan Review Committees (BTPRC) policy was followed. Numerator: Number of records being reviewed where the BTPRC policy was followed. Denominator: Number of records reviewed with Behavioral Treatment Plan.

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

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

		Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of completed Individual Plans of Service (IPOS) with restrictions identified and are in compliance with HCBS requirements. Numerator: Completed IPOS with restrictions identified that are in compliance with HCBS requirements. Denominator: All completed IPOS with restrictions identified.

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

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

Data Aggregation and Analysis:

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

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

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 records being reviewed where the waiver participants received health care appraisal. Numerator: Number of records being reviewed where the waiver participants received health care appraisal. Denominator: Number of records reviewed.

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

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

MDHHS will analyze a 100% of all reported critical incidents involving HSW participants from the CIRS, as well as analyze subcategories of critical incidents reported through the CIRS including who required hospitalization due to an injury related to use of physical management or due to medication error. The data will be used to establish a baseline "occurrence rate" and targets will be established to measure whether the rates decrease, increase or remain unchanged as policies and approaches are implemented. MDHHS and the Quality Improvement Council are particularly interested in evaluating and analyzing the rate of critical incidents as a means of measuring the effectiveness of preventive strategies.

MDHHS also has regular meetings with LARA Licensing staff to identify issues of concern related to people living in licensed settings.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

If an incident is reported to the CMHSP ORR or CMHSP, the system described in this Appendix would require the following steps be taken. Any critical incident for a beneficiary has a short-term response to assure the immediate health and welfare of the beneficiary for whom the incident was reported and a longer- term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified. Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the beneficiary's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up.

If an egregious event is reported through the Event Notification or through other sources, MDHHS may follow-up through a number of different approaches, including sending a site reviewer or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the PIHP, requiring additional training for PIHP providers, or other strategies as appropriate. During a MDHHS site visit, if the site review team member identifies an issue that places a beneficiary in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.

ii. Remediation Data Aggregation

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

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

Responsible Party*(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:

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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Improvement Council (QIC) has primary responsibility for identifying and prioritizing needs related to the Quality Improvement Strategy (QIS), which would include changes to HSW quality processes as applicable. The Quality Improvement Council meets every other month basis to review data and information from numerous sources, such as site review findings, 372 reports, state-level workgroups for practice improvement, EQR standard and special project reports, legislative reports, and QAPIP and PIP activities. The QIC determines where there are needs for system improvement and makes recommendations to MDHHS to incorporate into system improvement activities. The timeframe for incorporating changes is dependent on whether it is an issue requiring immediate enactment which would be addressed through policy changes or an amendment to the MDHHS/CMHSP and MDHHS/PIHP contracts. Otherwise, changes to the QIS are generally implemented in conjunction with the annual contracts between MDHHS and the PIHPs and CMHPS.

The MDHHS incorporates all of the programs operated in the public mental health system, including the Michigan 1115 Behavioral Health Demonstration, Habilitation Support Waiver (HSW), Children's Waiver Program (CWP), and the Waiver for Children with Serious Emotional Disturbance (SEDW). The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of fund source. The MDHHS Site Review team will conducts comprehensive annual reviews at each PIHP (and affiliate CMHSPs). The site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of §1915(c) waiver beneficiaries are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, beneficiary consumer/community partner stakeholder meetings and beneficiary consumer interviews. In addition to identifying individual issues that are addressed in remediation, the MDHHS findings are also used for identifying trends to implement systems improvements. This site visit strategy covers all beneficiaries served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver beneficiary.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Behavioral Health Code Charts and Provider Qualifications; review of PIHP policy for the Critical Incident Reporting System and verification that the process is being implemented per MDHHS policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDHHS policy; and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code.

As identified throughout this application, the annual site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random sample at the 95% confidence level for the annual review for each PIHP/CMHSP. At the site review, clinical record reviews are completed to determine that the IPOS:

- Includes services and supports that align with and address all assessed needs
- addresses health and safety risks
- is developed adhering to the CFA&P requirements, INCLUDING ALIGNMENT WITH MDHHS-APPROVED CFA&P SCENARIOS AND ANY ASSOCIATED CFA&P IMPLEMENTATION PLANS
- is updated at least annually

Clinical record reviews are also completed to determine that beneficiaries are afforded choice between waiver services and institutional care and between/among service providers and that services are provided as identified in the IPOS.

MDHHS contracted staff conducts beneficiary interviews with a random sample of those beneficiaries whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with beneficiaries who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the waivers.

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

MDHHS site reviews are shared with MDHHS management team, the Quality Improvement Council (QIC), and AHCBS staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Michigan's QAPIP has been developed with the input of beneficiaries and the Mental Health QIC. Michigan's QAPIP is revised with the Michigan 1115 Behavioral Health Demonstration and reflects the activities, concerns, input or recommendations from the MDHHS's Encounter Data Integrity Team (EDIT), EQR activities and the terms and conditions from CMS' previous waiver approvals. The MDHHS Site Review Protocol is reviewed and revised to address changes in policy resulting from trends or system improvements.

The existing infrastructure in Michigan includes Michigan 1115 Behavioral Health Demonstration to allow Michigan to provide mental health services not otherwise covered under the State Plan through a managed care delivery system. The concurrent §1115/1915(c) waivers enables Michigan to use Medicaid managed care program features such as quality improvement performance plans and external quality reviews as important parts of effective monitoring of the HSW.

Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the Quality Assessment and Performance Improvement Programs. These elements were required as part of the AFP (2002) and are now part of the MDHHS/PIHP contracts and they are reviewed by MDHHS staff and/or the EQR process. While a review of the following three areas is not specific to the HSW, it assures overall quality services for all beneficiaries.

EQR activities are conducted on PIHPs and primarily focus on the presence of PIHP policy and processes and evidence that those policies and processes are being implemented. MDHHS contracts with Health Services Advisory Group (HSAG) to conduct the EQR. The EQR consists of desk audits of PIHP documents, on- site visits to PIHPs or both. One EQR component addresses PIHP compliance to BBA requirements. The other two EQR activities involve validation of PIHP performance improvement projects and performance indicators.

The EQR address requirements for customer services: staff who are knowledgeable about referral systems to assist beneficiaries in accessing services, a range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSPs network, performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP, focus of customer services is customer satisfaction and problem avoidance, assures timely access to services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications, and the relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Appeals and Grievances Mechanisms: The EQR reviews the process, information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record- keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDHHS. MDHHS uses its Appeals and Grievances database to track the trends of the types of requests for fair hearing and their resolution, to identify PIHPs that have particularly high volumes of appeals, to identify themes, such as appeals related to a specific service and to address any trends that are noted through training, policy clarification, or other methods. MDHHS also has regular meetings with the Administrative Tribunal to address trends and identify solutions.

Quality Assessment and Performance Improvement Programs: The MDHHS contracts with PIHPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors the PIHP implementation of their local QAPIP plans that must include the required standards. MDHHS site reviews include review of implementation of standards for sentinel events and credentialing of providers. MDHHS collects data for performance indicators and performance improvement projects as described in b.i. below.

In addition to the AHCBS strategies implemented for all beneficiaries, the HSW staff review all applications and

monitor the timeliness of re-certifications by way of the web-based HSW database. The HSW staff may participate in MDHHS site reviews of clinical and administrative records or provide technical consultation as requested by the Site Review Team during a PIHP/CMHSP review.

Data from site reviews and consultations has been used for systems improvement activities. Examples include: providing technical assistance to PIHPs and CMHSPs; mandating technical assistance for sites with high levels of out-of-compliance; completing additional follow up record reviews to ensure Quality Improvement Project is being implemented; and identifying topics for technical assistance webinars or conferences at both state and local levels to address systemic issues.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: The QIC meets every other month. For the PIHPs/CMHSPs and MDHHS, QI activities are on-going.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

MDHHS uses performance indicators to measure the performance of the PIHP/CMHSP on a number of domains: access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management. Data collected for performance indicators can be identified at the individual HSW beneficiary level if necessary.

Indicators are used to alert MDHHS of systemic issues and PIHP/CMHSP-specific issues that need to be addressed immediately; to identify trends to watch; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter data located in MDHHS's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDHHS and the EQR. Analysis of the data results in statewide averages and in comparisons among PIHP/CMHSPs. Statistical outliers are reviewed to identify best practices as well as to identify opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and may lead to PIHP/CMHSP contract action. Technical information from the performance indicators is shared with PIHP/CMHSPs; user-friendly information is shared with the public using various media, including the MDHHS web site. Results of the performance indicators are shared with MDHHS management team, the QIC and HSW staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Beneficiary level demographic data are reported monthly for each beneficiary. Demographic data housed in the Behavioral Health Treatment Episode Data Set (BH-TEDS) is used for identifying the residential living arrangement for HSW beneficiaries, which is used in calculating the HSW capitation payment. A significant amount of work was done between MDHHS Federal Compliance Section and the PIHPs to identify the process and challenges with demographic data used by the HSW for payment calculations. The process for assigning a residential living arrangement code was incorporated into the HSW web-based database, which must be in agreement with the demographic data submitted by the PIHP before enrolling a HSW beneficiary. This process improvement has significantly increased the accuracy and timeliness of demographic data submissions for HSW beneficiaries in particular. Aggregate data from the encounter data system are shared with the MDHHHS management team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

PIHPs are required by contract to submit Medicaid Utilization and Net Cost (MUNC) reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP and can be analyzed at the HSW beneficiary level. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDHHS to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDHHS management team, the EDIT, and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Critical Incidents are reported, reviewed, investigated and acted upon at the local level by each PIHP for all HSW beneficiaries, as well as the following groups: beneficiaries receiving Targeted Case Management, beneficiaries enrolled in the CWP and the SEDW, and those living in 24-hour specialized residential settings, or in their own homes receiving ongoing and continued personal care services.

Michigan law and rules require the mandatory reporting of all recipient rights complaints within 48 hours to the CMHSPs. This information is reported in the aggregate to the MDHHS semi-annually. Aggregate data are shared with MDHHS management team, the QIC and staff from the Federal Compliance Section. Information is used by MDHHS to take contract action as needed, becomes the focus of on-site reviews conducted by MDHHS, and by the QIC to make recommendations for system improvements.

Semi-annually, local CMHSP Offices of Recipient Rights (ORR) report summaries of all allegations received and investigated, identify intervention taken, and the number of allegations substantiated. The summaries are reported by category of rights violations. An annual report is produced by the State ORR and submitted to community partners and the Legislature. Data collection improvements distinguish Medicaid beneficiaries from other beneficiaries that are served.
Information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDHHS management team, the QIC, and staff from Federal Compliance Section. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

The EQR process checks for PIHP policy and processes and evidence that those policies and processes are being implemented. Although the data is not necessarily specific to the HSW, because HSW beneficiaries represent a significant percentage of the Medicaid beneficiaries who have intellectual/developmental disabilities, the findings of PIHP performance are considered a valid data source for assuring the PIHP policies and procedures in the 13 areas are met. This data source is also used to identify areas for system design change and improvements.

The MDHHS staff collaborates with the Quality Improvement Council to identify the performance improvement projects for each waiver period. Justification for the projects was derived from analysis of quality management data, external quality review findings, and community partner concerns. Michigan requires all PIHP/CMHSPs to conduct a minimum of two performance improvement projects. All PIHP/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDHHS; in the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide. All PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHP/CMHSPs choose their second performance improvement project.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the State mandated project. Results of the MDHHS performance improvement project reports are shared with MDHHS management team, the QIC and HSW staff.

PIHP/CMHSPs found out of compliance with customer service standards (as defined a.i. above) must submit plans of correction. MDHHS staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDHHS site reviews and the EQRs are shared with MDHHS management team and the QIC. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Improvement Council (QIC) meets every other month and is the primary group responsible for reviewing the State's quality improvement strategy and making recommendations for changes to the strategy. The QIC would address QI strategies and systems improvements required for the HSW, as well as all the waiver populations served by Michigan's mental health system. The QIC also has a formal opportunity to identify issues at a meeting in anticipation of the annual contract renewal. To the extent that the MDHHSS/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract. If the QIC were to identify an issue that would require changes to the contract prior to the expiration of the current contract, the MDHHS could amend the contract. Procedural changes that do not require contract changes can be implemented immediately. Additionally, if issues are identified through trending and analysis, the QIC may make recommendations to MDHHS upper management team to revise the QIS. The final decision on changes to the QIS is made by the MDHHS upper management team.

The MDHHS leadership meets regularly with the PIHP and CMHSP directors and quality improvement strategies may be discussed during the course of those meetings. Feedback from the group is used to help evaluate the QI process and identify opportunities for improvements to MDHHS management team and the QIC.

In addition, as described in H-1-a-i above, trend patterns identified through a number of quality activities have been used to develop strategies for improvement. Data from site reviews and consultations have been used for systems improvement activities. Examples include: developing workshops for the Annual Statewide Waiver conference, monthly PIHP HSW Coordinators meetings, and identifying topics for technical assistance calls at both state and local levels to address systemic issues.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- **No**

- (●) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- (●) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Habilitation Supports Waiver operates concurrently with the Michigan 1115 Behavioral Health Demonstration. The HSW capitation payments are made to the PIHPs for the delivery of waiver services and PIHPs in turn, pays within [and when requested, outside] their networks of contracted providers. There are no fee-for-service payments for waiver services.

a) The MDHHS/PIHP contract includes requirements for PIHPs to complete independent audits.
b) Pursuant to the MDHHS/PIHP and MDHHS/CMHSP contracts, PIHPs and CMHSPs must submit to MDHHS a Financial Statement Audit and a Compliance Examination Report conducted in accordance with the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements 10 and the CMH Compliance Examination Guidelines attached to the MDHHS/PIHP and MDHHS/CMHSP contracts.

The annual independent financial audit must clearly indicate the operating results for the reporting period and financial position of the PIHP at the end of the fiscal year. The Financial Statement Audit must be conducted in accordance with Generally Accepted Auditing Standards.

The annual CMHSP Compliance Examination requires that an independent auditor examine compliance issues related to contracts between PIHPs and the MDHHS to manage the concurrent §1115 and the 1915(c) waiver programs as well as general fund and Mental Health Block Grant funds. PIHPs must assure that compliance issues are monitored by either requiring their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs or require the affiliated CMHSPs to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. The CMH Compliance Examination does not replace or remove any other audit requirements that may exist, such as a financial statement audit and/or a single audit.

The PIHP must submit to MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end.

PIHPs/CMHSPs are obligated to comply with the Balanced Budget Act (BBA) of 1997. Among the State's BBA- compliant Quality Standards is the requirement for CMHSPs to develop a methodology for verifying that Medicaid services claimed by providers are actually delivered. This verification must include: If the code is approved under this contract, eligibility of the beneficiary on the date of service, service is included in the beneficiary's Individual Plan of Service (IPOS), the date/time of service, service provided by a qualified practitioner and falls within the scope of the code billed/paid, amount billed does not exceed the payer's (PIHP or CMHSP) contracted amount, and amount paid does not exceed the payer's (PIHP or CMHSP) contracted amount. Verification procedures must utilize statistically sound sampling methodology in accordance with Office of Inspector General (OIG) standards. PIHP methodology must identify and document the sampling methodology used to determine sampling and describe any tools used to assist in the sample determination process. This process identifies potential issues across persons served including the HSW population. Any issues identified in this process would be expected to be included in quarterly Program Integrity Activities reports submitted by PIHPs.

In addition to the Financial Statement Audit and the Compliance Examination, PIHPs and CMHSPs that expend $750,000 or more in federal awards during their fiscal year must submit to MDHHS a Single Audit prepared consistent with the Single Audit Act of 1996 and OMB Circular A-133.

MDHHS uses the HIPAA 820/834 capitation payment and enrollment report systems to generate capitation payments to PIHPs. The 834 process generates an enrollment file based upon the PIHP provider ID number and the beneficiary's assignment to the HSW Managed Care benefit plan. This process uses edits to assure only the PIHPs that have a contract with the State are provided the capitation payment for the HSW. Each PIHP has a unique state-specific provider ID number in the system. The system will only generate payments for the provider ID number that is specific to a contracted PIHP. This process includes verifying the beneficiary's Medicaid eligibility and HSW benefit plan. Once all eligible beneficiaries are identified, the 820 process generates a capitation payment for each PIHP using the Medicaid Management Information System (MMIS). MDHHS utilizes a retrospective review period to account for recoupments and repayments based upon updated data obtained through the 834 process.

The repayment and recoupment processes are for the capture and correction of funds for beneficiaries who enrolled or disenrolled in the PIHPs after the capitation payments were issued. The repayment process is the provision of a capitation payment for beneficiaries enrolled in the HSW during a given month when the PIHP did not receive a capitation payment due to data lags in the 834 process. The recoupment process is the recovery of capitation payments for beneficiaries who disenrolled from the HSW but the PIHPs received capitation payments due to data lags in the 834 process.

MDHHS has developed a report in the HSW database to monitor beneficiaries who are not receiving any HSW services.

For HSW services that are in-scope for Electronic Visit Verification (EVV), which include Community Living Supports and Respite services, there is an additional layer of oversight and accountability, provided through the State sponsored EVV solution. For these services, MDHHS has executed a contract for a State sponsored EVV solution that will operate across all applicable waivers and state plan services. The State sponsored EVV solution includes a pre-billing component to ensure that only clean claims can be successfully adjudicated/processed. Claim submissions that do not pass the pre-billing process will result in a notification being sent through the system indicating that the claim requires correction.

c) The PIHPs are responsible for having independent audits completed as noted above. At the state level, the MDHHS Office of Audit and the MDHHS review the reports, issue management decisions, and follow-up as needed.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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 HSW encounters submitted to MDHHS with all required data elements. Numerator: Number of HSW encounters submitted to MDHHS with all required data elements. Denominator: Number of encounters submitted to MDHHS for HSW participants sampled.

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

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

☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *95*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☑ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***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 PIHP only for HSW participants with active Medicaid eligibility. Numerator: Number of capitation payments made to the PIHP for HSW participants with active Medicaid eligibility. Denominator: All capitation payments for HSW participants sampled.

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

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

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Number of capitation payments made to PIHPs at the approved rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS for HSW participants sampled.

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

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

☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *95*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☑ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

The MDHHS Site Review process includes an examination of the beneficiary's IPOS and the supporting documentation that the services were delivered that were appropriate to the beneficiary's identified needs in the amount, scope, duration, and frequency specified in the IPOS.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

MDHHS has developed a report in the HSW database to track and monitor the HSW beneficiaries not receiving HSW services on a quarterly basis. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's beneficiaries. For active HSW beneficiaries not receiving HSW services in three consecutive months, MDHHS Federal Compliance Manager and HSW staff will provide technical guidance with the PIHP and may recommend disenrollment from the HSW.

MDHHS Office of Audit reviews the Financial Statement Audit and Compliance Examination Reports. The State will issue a management decision on findings, comments, and questioned costs contained in PIHP Financial Statement Audit and Compliance Examination Report. The management decision relating to the Financial Statement Audit will be issued within six months after the receipt of a complete and final reporting package. The management decision relating to the Compliance Examination will be issued within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the finding or comment is sustained; the reasons for the decision, and the expected Contractor action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, the State may request additional information or documentation from the PIHP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs.

Per the MDHHS/PIHP contract, the PIHP must include program integrity compliance provisions and guidelines in all contracts with subcontracted entities/network providers and if program integrity compliance activities are delegated to subcontractors, the subcontract must comply with the requirements outlined in the MDHHS/PIHP contract. This includes submission of quarterly reports detailing program integrity compliance activities, assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity, provisions for routine internal monitoring of program integrity compliance activities, prompt Response to potential offenses and implementation of corrective action plans, prompt reporting of fraud, waste, and abuse to PIHP and implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities' employees at all levels. For cases of fraud, waste and abuse where it is determined to be a civil infraction Medicaid determines the appropriate action. If it is determined to be a criminal matter, Medicaid refers it to the state Office of the Attorney General (OAG), Abuse and Fraud Division, for follow-up. The OAG investigates the complaint to determine its validity and to determine whether criminal action should be initiated and if restitution or recovery is the appropriate response. The OAG maintains communication with Medicaid throughout the investigation and resolution.

If the MDHHS site review notes individual issues related to service delivery as specified in the plan, the deficiency is noted in the report and the PIHP is required to submit a plan of correction to address. Individual remediation is expected within 90 days after the PIHP plan of correction has been reviewed and accepted by MDHHS. Systemic remediations will be reviewed for effectiveness at the next scheduled site review.

ii. Remediation Data Aggregation

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

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

Responsible Party*(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:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

This §1915(c) waiver operates concurrently with the Michigan 1115 Behavioral Health Demonstration. Please refer to the Michigan's §1115 Waiver application and associated materials.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The PIHP contracted providers submit HSW services encounters/claims to the PIHPs; the clean claims are then adjudicated and paid [out of the PIHP's capitation funds] within the payment timeliness parameters specified in their PIHP contracts; the definition of clean claim, the flow of billings, and the payment timeliness parameters, etc. are governed by the MDHHS/PIHP contract requirements.
Pursuant to Section 12006(a) of the 21st Century Cures Act, Michigan continues to actively pursue successful implementation of Electronic Visit Verification (EVV) within all applicable waivers and state plan services, including the HSW, for in-scope Personal Care Services (as defined by the Cures Act) that require an in-home visit by a provider. Michigan has selected the Open Vendor model and has executed a contract with a vendor to provide a State sponsored EVV solution. Michigan's current contract allows providers to either use the State sponsored EVV solution as their primary method of EVV reporting, or an alternate approved EVV systems. Michigan's EVV solution is designed to collect all 6 required data elements including the type of service performed, individual receiving the service, date of the service, location of the service delivery, individual providing the service, and the time the services begins and ends. Michigan's EVV system also includes a pre-billing component that supports only clean claims being successfully adjudicated/processed. Claim submissions that do not pass the pre-billing process will result in a notification being sent through the system indicating that the claim requires correction. Behavioral Health implementation, including the HSW, is scheduled to go-live with EVV implementation by September 2024, and MDHHS remains committed to ongoing compliance beyond that date. Current in-scope services for the HSW include Community Living Supports and Respite services.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ○ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ● ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☑ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

a) For this waiver, the PIHP incurs certified public expenditures (the CMHSP is a local government agency).
b) The PIHPs collect and calculate actual cost data and attest to the fact that the data reporting is accurate. Costs are reported through various financial documents both throughout the fiscal year and at the close of the fiscal year and are subject to annual auditing to assure that the CPE is based on total computable costs for the concurrent 1115/1915(c) waiver.
c) Expenditures are based on eligibility, reporting of encounters for the provision of valid waiver services and the cost for providing those services. CHAMPS verifies eligibility. Annual audit compliance exams are used to verify that the CPE are properly identified, categorized, distributed, and reported by fund source are eligible for FFP. MDHHS reviews the annual compliance exam to assure that any irregularities are addressed by the PIHP.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The quarterly CMS 64 Claims for federal financial participation for this waiver program are made based on the monthly §1915(c) waiver capitation payments made to the PIHPs on behalf of the beneficiary enrolled in this waiver program.
a) These capitation payments are made only after each beneficiary active Medicaid eligibility has been verified through CHAMPS. Per the performance measure in the QIS for this appendix, a representative random sample of all HSW beneficiaries is reviewed to assure that capitation payments are made only for HSW beneficiaries with active Medicaid eligibility.
b) The MDHHS Site Review Team reviews a proportionate random sample of HSW beneficiaries during each comprehensive full review. This review includes an examination of the beneficiary's IPOS and the supporting documentation (e.g., progress notes, time sheets or any other relevant evidence) that the services were delivered that were appropriate to the beneficiary's identified needs in the amount, scope, duration and frequency specified in the IPOS. This is reflected in a performance measure in the QIS for Appendix D.
c) MDHHS Federal Compliance Section developed a report in the HSW database to track and monitor the HSW beneficiaries not receiving HSW services on a quarterly basis. Report will look at HSW encounters submitted by the PIHP. Findings and trends will be shared at the annual rate setting meeting with the State's actuary to develop the capitation rates for this waiver program's beneficiaries. For active HSW beneficiaries not receiving HSW services in three consecutive months, MDHHS Federal Compliance Manager will provide phone consultations with the PIHP and may recommend disenrollment from the HSW. MICHIGAN INTENDS TO IMPLEMENT A PRE-PAYMENT CLAIMS VALIDATION PROCESS FOR SERVICES THAT ARE IN-SCOPE FOR EVV, HOWEVER FURTHER DISCOVERY IS REQUIRED IN ORDER FOR THAT TO OCCUR. IN THE INTERIM, MICHIGAN WILL IMPLEMENT A POST-PAYMENT VALIDATION PROCESS, WHICH WILL OCCUR AT INITIAL GO-LIVE FOR BEHAVIORAL HEALTH. THIS POST PAYMENT VALIDATION PROCESS WILL USE THE PAID CLAIMS FILE (CLAIMS AND ENCOUNTERS) FROM THE CHAMPS SYSTEM AGAINST VISIT INFORMATION DATA THAT EXISTS WITHIN THE HHAEXCHANGE SYSTEM (STATE SPONSORED EVV SOLUTION).

The MDHHS/PIHP contract specifies the Claims Management requirements incumbent upon the PIHPs and the providers within their networks. It is the encounter and cost data governed by these claims management requirements that constitutes the data basis from which the States actuary develops the capitation rates for this waiver programs beneficiaries.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

As noted in I-1, the HSW database is the system of record for enrollment into the waiver. On a monthly basis, enrollment data and associated payment elements, such as the residential living arrangement, are interfaced from the HSW database to CHAMPS. If the HSW participant is Medicaid eligible when the interface file is processed, an eligibility record is established in CHAMPS and the HSW benefit plan is opened. If the HSW participant is non-Medicaid eligible, notification is sent back to the HSW database advising that a particular record did not process for payment and must be resubmitted next cycle. If the HSW benefit plan is open, the PIHP receives an electronic member file (834) containing HSW enrollment and eligibility information. Prior to payment, Medicaid eligibility is verified again by CHAMPS. If the HSW participant has retained Medicaid eligibility, a capitation payment is issued. On a monthly basis, wire transfers of the HSW capitation payments are made by MDHHS to the PIHPs accounts and a payment record (820) is issued to the PIHP.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- ☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- ☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

not applicable

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The PIHPs receive capitation payments and furnish, either directly or through contracts with networks of qualified providers which includes the CMHSPs (who are local governmental entities), the full array of this waiver's services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the §1115/1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS-64 summary sheet.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The MDHHS/PIHP contract is a cost settled, shared risk contract. Per the provisions of the contract, any unspent funding is reported as Medicaid savings and reinvested in the next fiscal year as allowed by the §1115 /1915(c) concurrent waiver or returned during the cost settlement process with the federal portion being returned to the federal government via the CMS-64 summary sheet.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may

voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☑ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

● ***Applicable***

Check each that applies:

☑ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government

agencies as CPEs, as specified in Item I-2-c:

Financing for Medicaid services is contingent on the annual Appropriation Act. Per the MDHHS/PIHP contract the PIHP must provide to the State, for deposit into a separate contingency account, local funds as authorized in the State Appropriations Act.
a) County governments have the authority to levy taxes. CMHSPs may receive county appropriations or other revenues described below.
b) Per the MDHHS/CMHSP contract, the sources of other revenue are described in Section S. Fiscal Audits and Compliance Examination. The revenue sources include general county appropriations, other appropriations and service revenues, gifts and contributions, special fund account, investment interest, and other revenues for mental health.
c) The mechanism used to transfer funds to the Medicaid Agency is an intergovernmental transfer, specifically the PIHP shall provide to MDHHS on a quarterly basis the PIHP obligation for local funds as a bona fide source of match for Medicaid.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home***

of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The requirement to exclude room and board costs from Medicaid payments is stated in the Michigan Medicaid Provider Manual, as well as within the MDHHS Contract with the PIHPs. The PIHPs pay for HSW services. The other costs of the subcontractor residential provider, including room and board, can only be paid by using SSI or state general fund dollars.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	83565.89	33846.00	117411.89	138102.00	17156.00	155258.00	37846.11
2	91371.28	35274.00	126645.28	143349.00	17671.00	161020.00	34374.72
3	95015.20	36332.00	131347.20	148797.00	18201.00	166998.00	35650.80
4	99052.07	37523.00	136575.07	154451.00	18747.00	173198.00	36622.93
5	102775.42	38545.00	141320.42	160320.00	19309.00	179629.00	38308.58

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	8268	8268
Year 2	8268	8268
Year 3	8268	8268
Year 4	8268	8268
Year 5	8268	8268

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) HAS BEEN PROJECTED BASED ON SFY 2024 HISTORICAL EXPERIENCE, REFLECTING YEAR-OVER-YEAR INCREASES DURING THE NEW 5-YEAR WAIVER PERIOD BASED ON PROJECTED PHASE-IN AND PHASE-OUT ASSUMPTIONS. THE CALCULATION OF THE ALOS ESTIMATE FOR WY 1 IN THE RENEWAL PERIOD IS EQUAL TO THE PROJECTED TOTAL NUMBER OF DAYS FOR MEMBERS ON THE WAIVER DURING WY 1 DIVIDED BY THE UNDUPLICATED PARTICIPANT COUNT. THE ALOS IS CALCULATED BASED ON ACTUAL EXPERIENCE THROUGH SEPTEMBER 2024 AND ESTIMATED PHASE-IN AND PHASE-OUT ASSUMPTIONS FOR FUTURE TIME PERIODS. CHANGES IN ALOS OVER THE COURSE OF THE 5-YEAR RENEWAL PERIOD ARE BASED ON PROJECTED CHANGES IN ENROLLEES OVER THE WAIVER PERIOD AND REFLECT SLIGHTLY SHORTER STAYS IF MORE PEOPLE PHASE INTO THE WAIVER THAN PHASE OUT IN A GIVEN YEAR.

AS SEEN IN THE FACTOR D DEVELOPMENT TABLES, WY 1 IS PROJECTED TO HAVE A SLIGHTLY SHORTER ALOS THAN WY 2 THROUGH WY 5 BECAUSE OF THE PHASE-IN AND PHASE-OUT ASSUMPTIONS CHANGE FROM WY 1 TO WY 2, WHICH ARE DRIVEN BY PROJECTED GROWTH IN UNDUPLICATED PARTICIPANTS FROM THE HISTORICAL PERIOD TO WY 1. THE INCREASE IN ALOS BETWEEN WY1 AND WY2 IMPACTS THE EFFECTIVE TREND FOR FACTOR D AND FACTOR D' MAKING THE EFFECTIVE TREND GREATER THAN THE ASSUMED ANNUAL COST PER UNIT TREND.

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:*

BASE UTILIZATION AND COST PER UNIT EXPERIENCE FOR FACTOR D HAS BEEN UPDATED TO USE SFY 2024 FINANCIAL AND ENCOUNTER DATA WHICH ALSO SERVES AS BASE DATA FOR THE SFY 2026 CAPITATION RATE DEVELOPMENT. THE EXPENDITURES FOR SEVERAL SERVICE CATEGORIES MATERIALLY CHANGED FROM THE EXISTING WAIVER RENEWAL BECAUSE THE WAIVER RENEWAL APPLICATION RELIED UPON SFY 2022 BASE DATA. ALL UPDATES TO ASSUMPTIONS, METHODOLOGIES, AND POLICY CHANGES RELATED TO THE FACTOR D DERIVATION IN THIS AMENDMENT HAVE BEEN OUTLINED WITHIN THIS NARRATIVE. UNLESS OTHERWISE STATED, FACTOR D WAS PROJECTED IN THE FOLLOWING MANNER:

#USERS: THE PROJECTED NUMBER OF USERS OF EACH SERVICE DURING WY 1 WAS CALCULATED USING THE COMPOSITE UNDUPLICATED PARTICIPANT COUNT FOR WY 1 IN TABLE J-2-A MULTIPLIED BY RESPECTIVE USER PERCENTAGES FROM THE SFY 2024 BASE DATA. SINCE THE NUMBER OF UNDUPLICATED PARTICIPANTS IN TABLE J-2-A WAS PROJECTED STABLE ACROSS THE 5-YEAR WAIVER RENEWAL PERIOD, THE NUMBER OF USERS OF EACH SERVICE WAS ASSUMED CORRESPONDINGLY STABLE ACROSS THE 5-YEAR WAIVER RENEWAL PERIOD UNLESS OTHERWISE NOTED BELOW.

AVG UNITS PER USER: HISTORICAL AVERAGE UNITS PER USER FROM SFY 2024 BASE DATA WERE USED FOR PROJECTION OF WY1 UNITS PER USER FOR EACH FACTOR D SERVICE. ASIDE FROM THE EXCEPTIONS NOTED LATER IN THIS SECTION, THE YEAR-OVER-YEAR CHANGE IN ALOS WAS USED TO PROJECT AVERAGE UNITS PER USER BY WAIVER SERVICE FOR THE REMAINDER OF THE 5-YEAR PERIOD.

AVG COST/UNIT: BASELINE AVERAGE COST PER UNIT VALUES WERE CALCULATED USING SFY 2024 BASE DATA. UNLESS OTHERWISE SPECIFIED, THE AVERAGE COST PER UNIT FOR EACH WAIVER SERVICE WAS ESTABLISHED USING TOTAL EXPENDITURES BY WAIVER SERVICE DIVIDED BY THE TOTAL NUMBER OF UNITS.

COST/UNIT TREND ADJUSTMENT: CONSISTENT WITH SFY 2026 CAPITATION RATE DEVELOPMENT, THE AVERAGE COST PER UNIT FOR FACTOR D SERVICES WAS TRENDED FROM SFY 2024 TO WY 1 AND WY 2 USING AN ANNUAL TREND RATE OF 4.6% WHICH WAS INFORMED BY HISTORICAL HSW CLAIMS DATA, BUREAU OF LABOR STATISTICS (BLS) DATA, AND SFY 2024/SFY 2025 BEHAVIORAL HEALTH PROVIDER STAFFING AND EXPENSE SURVEY DATA SPECIFIC TO MICHIGAN MEDICAID PROVIDERS. A DETAILED DESCRIPTION OF THE METHODOLOGY IS DOCUMENTED IN THE SFY 2026 CAPITATION RATE CERTIFICATION. THE REMAINDER OF THE 5-YEAR PERIOD ASSUMED A 4.0% ANNUAL COST PER UNIT TREND CONSISTENT WITH THE ASSUMPTION IN THE EXISTING RENEWAL APPLICATION AND SUPPORTED BY THE THIRD-QUARTER 2024 HOME HEALTH INPUT PRICE INDEX FROM THE IHS GLOBAL INC. FORECAST RELEASED BY CMS, OACT, NATIONAL HEALTH STATISTICS GROUP, DNHS@CMS.HHS.GOV, ON 04/15/2025.

COST/UNIT DCW ADJUSTMENT: COST PER UNIT VALUES FOR DCW SERVICES WERE ADDITIONALLY ADJUSTED TO ACCOUNT FOR AN INCREASE IN MICHIGAN MEDICAID'S DCW HOURLY WAGE ADJUSTMENT OF $3.20 FOR SFY 2024 TO $3.40 FOR SFY 2025. THE ASSUMPTION OF A $0.20 HOURLY WAGE ADJUSTMENT BETWEEN SFY 2024 AND WY 1 IS CONSISTENT WITH THE EXISTING WAIVER RENEWAL. HOWEVER, COST PER UNIT ADJUSTMENTS IN THIS AMENDMENT WERE REVISED TO RECOGNIZE THAT DCW HOURLY WAGE ADJUSTMENTS IMPACT NOT ONLY DIRECT CARE BILLABLE HOURS, BUT ALSO INDIRECT CARE, PTO, HOLIDAYS, TRAINING, AND OVERTIME-RELATED COMPONENTS OF COST PER UNIT. THIS REVISION ALIGNS COST PER UNIT PROJECTIONS IN THIS AMENDMENT WITH COST PER UNIT ADJUSTMENTS IN THE SFY 2026 CAPITATION RATE DEVELOPMENT.

COST/UNIT MANAGED CARE ADJUSTMENT: COSTS PER UNIT VALUES FOR ALL FACTOR D SERVICES WERE INCREASED TO REFLECT HEALTH MAINTENANCE ORGANIZATION COSTS FOR ADMINISTRATION AND RISK MARGIN. FOR CONSISTENCY WITH THE SFY 2026 CAPITATION RATE DEVELOPMENT, THIS ADJUSTMENT HAS BEEN UPDATED TO REFLECT A COMPOSITE STATEWIDE LOAD OF 8.1%. THIS IS AN INCREASE FROM THE 5.0% ASSUMPTION USED IN THE PRIOR VERSION OF THIS AMENDMENT. THE 8.1% LOAD WAS INFORMED BY SFY 2024 FINANCIAL REPORTING BY

MICHIGAN'S PIHPS. A DETAILED DESCRIPTION OF THE METHODOLOGY IS DOCUMENTED IN THE SFY 2026 CAPITATION RATE CERTIFICATION.

YEAR-OVER-YEAR EFFECTIVE TRENDS: YEAR-OVER-YEAR EFFECTIVE TRENDS FOR FACTOR D IN APPENDIX J-1 REFLECT THE COMPOSITE OF PROJECTED CHANGES IN COST PER UNIT, AVERAGE UNITS PER USER, AND AVERAGE LENGTH OF STAY, AND, THUS, ARE NOT DIRECTLY COMPARABLE TO ANNUAL COST PER UNIT ASSUMPTIONS.

FACTOR D EXCEPTIONS - METHODOLOGY AND ASSUMPTIONS INCLUDED IN THE EXISTING WAIVER RENEWAL APPLICATION THAT REMAIN NECESSARY TO PROJECT SFY 2024 TO WY 1 ARE LISTED BELOW.

•PREVOCATIONAL SERVICES: REMOVED PREVOCATIONAL SERVICES FROM FACTOR D EFFECTIVE OCTOBER 1, 2024 AND SHIFTED SERVICE COSTS TO FACTOR D'. SINCE PREVOCATIONAL SERVICE COSTS OVERLAP WITH SERVICES PROVIDED UNDER STATE PLAN SKILL-BUILDING SERVICES, CORRESPONDING EXPENDITURES WERE INCLUDED WITH SKILL-BUILDING SERVICES IN FACTOR D'.

•GOODS AND SERVICES: EFFECTIVE OCTOBER 1, 2024, REMOVED LANGUAGE IN GOODS AND SERVICES THAT INDICATES IT MUST REPLACE SERVICES DONE BY A HUMAN.
O NUMBER OF USERS - WE ESTIMATE THIS WILL RESULT IN AN INCREASE IN THE NUMBER OF UNDUPLICATED ANNUAL USERS TO 25% OF THE ESTIMATED 2,144 SELF-DIRECTED HSW PARTICIPANTS PROJECTED FOR SFY 2025, OR 536 UNIQUE USERS IN WY 1. THESE VALUES HAVE BEEN UPDATED FROM THE EXISTING WAIVER RENEWAL APPLICATION TO REFLECT SFY 2024 BASE DATA.
O AVG. UNITS PER USER - RECIPIENTS WILL ONLY UTILIZE 1 UNIT PER YEAR FOR THIS SERVICE
O AVG. COST/UNIT - AVERAGE COST PER UNIT WAS ESTIMATED TO BE APPROXIMATELY 80% OF THE $2,000 MAXIMUM ALLOWED COST PER USER, OR APPROXIMATELY $1,600 PER UNIT.

•GOODS AND SERVICES: ADDED COVERAGE OF ADAPTIVE CLOTHING TO GOODS AND SERVICES EFFECTIVE OCTOBER 1, 2024
O NUMBER OF USERS - WE ESTIMATE THIS WILL RESULT IN AN INCREASE IN THE NUMBER OF UNDUPLICATED ANNUAL USERS BY 100 IN WY 1.
O AVG. UNITS PER USER - RECIPIENTS WILL ONLY UTILIZE 1 UNIT PER YEAR FOR THIS SERVICE
O AVG. COST/UNIT - AVERAGE COST PER UNIT WAS ESTIMATED TO BE $1,000.

FACTOR D NEW EXCEPTIONS - FACTOR D METHODOLOGY AND ASSUMPTIONS NEW TO THIS AMENDMENT ARE LISTED BELOW.

•PRIVATE DUTY NURSING: INCREASED COST PER UNIT VALUES FOR PRIVATE DUTY NURSING SERVICES BY 25% EFFECTIVE OCTOBER 1, 2024 PER LEGISLATIVE MANDATE.

•MICHIGAN MINIMUM WAGE: THE SFY 2026 CAPITATION RATE DEVELOPMENT REFLECTS THAT MICHIGAN'S MINIMUM HOURLY WAGE INCREASED TO $12.48 EFFECTIVE FEBRUARY 21, 2025 AND WILL FURTHER INCREASE TO $13.73 ON JANUARY 1, 2026.

ALTHOUGH CURRENTLY UNDER CONSIDERATION, MDHHS'S EXISTING POLICIES STATE THAT THE DCW WAGE ADJUSTMENT MUST BE IN ADDITION TO THE MINIMUM WAGE REQUIREMENTS (I.E., $13.73 + $3.40 OR $17.13 PER HOUR EFFECTIVE JANUARY 1, 2026). WHILE MICHIGAN'S MINIMUM WAGE WILL FURTHER INCREASE TO $15.00 ON JANUARY 1, 2027, THE FACTOR D PROJECTIONS IN THIS AMENDMENT INCLUDE NO ADDITIONAL WAGE INCREASES ASIDE FROM THE ANNUAL 4.0% COST PER UNIT TREND IMPACTING WY 3 THROUGH WY 5. THIS ASSUMPTION REFLECTS THE UNCERTAINTY RELATED TO THE FUTURE OF MDHHS'S DCW WAGE POLICY.

•EARNED SICK TIME ADJUSTMENT (ESTA): ON FEBRUARY 21, 2025, MICHIGAN SIGNED INTO LAW AN AMENDMENT TO THE ESTA. THE AMENDED ESTA GENERALLY REQUIRES EMPLOYERS TO PROVIDE ALL ELIGIBLE NON-EXEMPT EMPLOYEES WITH AN ACCRUAL OF ONE HOUR OF SICK TIME PER THIRTY HOURS WORKED UP TO A SPECIFIED LIMIT THAT WILL ROLL OVER TO THE FOLLOWING

YEAR. COST PER UNIT HAS BEEN ADJUSTED TO ALIGN WITH THE SFY 2026 CAPITATION RATE DEVELOPMENT, AND FROM ANALYSIS SUPPORTED BY MICHIGAN'S 2025 PROVIDER STAFFING AND EXPENSE SURVEY RESULTS WHICH INCLUDE PROVIDER SPECIFIC PTO DAYS IN COORDINATION WITH PART-TIME VERSUS FULL-TIME EMPLOYEE DISTRIBUTIONS.

•WASKUL LAWSUIT SETTLEMENT: APPENDIX J WAS UPDATED TO REFLECT THE IMPACT OF THE WASKUL LAWSUIT SETTLEMENT WHICH WILL INCREASE EXPENDITURES RELATED TO CLS AND OHSS BUDGET DEVELOPMENT FOR SELF-DETERMINATION PARTICIPANTS RECEIVING SERVICES THROUGH THE 1915(C) HSW EFFECTIVE OCTOBER 1, 2025. THE SETTLEMENT INCLUDED A DROP-DEAD DATE AFTER WHICH TIME, THE REQUIREMENTS IN ATTACHMENTS A THROUGH C OF THE SETTLEMENT DICTATE THE ACTIONS TO BE TAKEN BY MDHHS REGARDING INDIVIDUAL PLAN OF SERVICE (IPOS) BUDGET DEVELOPMENT FOR CLS AND OHSS SERVICES FOR THE APPLICABLE HSW RECIPIENTS. ATTACHMENT C REQUIRES A PROCESS OF "COSTING OUT" CLS AND OHSS-RELATED EXPENDITURES TO DEVELOP AN IPOS-SPECIFIC BUDGET WHICH INCLUDES ALL EXPENDITURE COMPONENTS OUTLINED IN ATTACHMENT C AND MEETS THE DEFINITION OF ATTACHMENT B MEDICAL NECESSITY CRITERIA FROM THE SETTLEMENT DOCUMENT. "COSTING OUT" WILL OCCUR INDEPENDENTLY FOR EACH RECIPIENT BASED UPON THEIR IPOS. A DETAILED DESCRIPTION OF THE METHODOLOGY, USED FOR BOTH THIS AMENDMENT AND CORRESPONDING CAPITATION DEVELOPMENT, IS DOCUMENTED IN THE SFY 2026 CAPITATION RATE CERTIFICATION. THIS ADJUSTMENT INCREASED PROJECTED CAPITATION RATE FUNDING FOR SFY 2026 BY APPROXIMATELY $12.9 MILLION PRIOR TO ADJUSTMENTS FOR HEALTH MAINTENANCE ORGANIZATION ADMINISTRATION AND RISK MARGIN.

•CLS NON-LICENSED RESIDENTIAL PER DIEM SERVICE OPTION: DEVELOPMENT OF FACTOR D IN THE EXISTING WAIVER RENEWAL INCLUDES CLS NON-LICENSED RESIDENTIAL SERVICE (PER 15 MINUTES) AS A COVERED SERVICE. FOR THIS AMENDMENT, MDHHS IS EXPANDING COVERED SERVICES TO INCLUDE A PER DIEM CLS SERVICE OPTION EFFECTIVE FOR WY2 (OCTOBER 1, 2025) AND THE REMAINDER OF THE 5-YEAR WAIVER RENEWAL PERIOD. TO MODEL THE IMPACT ON A BUDGET-NEUTRAL BASIS AND REFLECT THE SPECIFIC MMDHS POLICY FOR BILLING OF CLS PER DIEM SERVICES, WE HAVE ASSUMED A SHIFT OF ENCOUNTERS WITH 10 OR MORE HOURS (40 OR MORE 15-MINUTE UNITS) TO THE PER DIEM ROW OF APPENDIX J-2-D. THE COST PER UNIT FOR THE PER DIEM SERVICE HAS BEEN DEVELOPED BY MULTIPLYING THE 15-MINUTE COST PER UNIT EFFECTIVE FOR WY 2 BY THE AVERAGE NUMBER OF 15-MINUTE UNITS CORRESPONDING TO ALL ENCOUNTERS WITH 10 OR MORE HOURS. DIVIDING THE WY 2 PER DIEM COST PER UNIT FROM APPENDIX J-2-D BY THE CORRESPONDING 15-MINUTE UNIT ILLUSTRATES AN ASSUMED AVERAGE HOURS PER ENCOUNTER OF 14.3 FOR CLS ENCOUNTERS WITH 10 OR MORE HOURS.

•OHSS PER DIEM SERVICE OPTION: DEVELOPMENT OF FACTOR D IN THE EXISTING WAIVER RENEWAL INCLUDES OHSS (PER 15 MINUTES) AS A COVERED SERVICE. FOR THIS AMENDMENT, MDHHS IS EXPANDING COVERED SERVICES TO INCLUDE A PER DIEM OHSS SERVICE OPTION EFFECTIVE FOR WY2 (OCTOBER 1, 2025) AND THE REMAINDER OF THE 5-YEAR WAIVER RENEWAL PERIOD. TO MODEL THE IMPACT ON A BUDGET-NEUTRAL BASIS AND REFLECT THE SPECIFIC MMDHS POLICY FOR BILLING OF PER OHSS DIEM SERVICES, WE HAVE ASSUMED A SHIFT OF ENCOUNTERS WITH 6 OR MORE HOURS (24 OR MORE 15-MINUTE UNITS) TO THE PER DIEM ROW OF APPENDIX J-2-D. THE COST PER UNIT FOR THE PER DIEM SERVICE HAS BEEN DEVELOPED BY MULTIPLYING THE 15-MINUTE COST PER UNIT EFFECTIVE FOR WY 2 BY THE AVERAGE NUMBER OF 15-MINUTE UNITS CORRESPONDING TO ALL ENCOUNTERS WITH 6 OR MORE HOURS.

DIVIDING THE WY 2 PER DIEM COST PER UNIT FROM APPENDIX J-2-D BY THE CORRESPONDING 15-MINUTE UNIT ILLUSTRATES AN ASSUMED AVERAGE HOURS PER ENCOUNTER OF 8.4 FOR OHSS ENCOUNTERS WITH 6 OR MORE HOURS.

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:*

THE BASE EXPERIENCE FOR THE FACTOR D' EXPENDITURES FROM THE EXISTING WAIVER RENEWAL TO REFLECT SFY 2024 ENCOUNTER, FEE-FOR-SERVICE (FFS), AND FINANCIAL DATA HAS BEEN UPDATED.

WITH THE EXCEPTION OF HOME HELP SERVICES, FACTOR D' WAS TRENDED AT A RATE OF 3.0% PER YEAR BASED UPON THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS (CPI-U): MEDICAL CARE SERVICES FOR THE PERIOD OF MAY 2024 THROUGH MAY 2025. THE COST PER UNIT RATE REQUIRED FOR HOME HELP SERVICES INCREASED TO $15.88 PER HOUR FOR INDIVIDUAL PROVIDERS AND $27.00 PER HOUR FOR AGENCY DIRECTED SERVICES EFFECTIVE 10/1/2024 AND WAS INCLUDED IN THE PROJECTION OF WY 1 THROUGH REPRICING OF EXPENDITURES. YEAR-OVER-YEAR EFFECTIVE TRENDS FOR FACTOR D' IN APPENDIX J-1 REFLECT THE COMPOSITE OF PROJECTED CHANGES IN COST PER UNIT, AVERAGE UNITS PER USER, AND AVERAGE LENGTH OF STAY, AND, THUS, ARE NOT DIRECTLY COMPARABLE TO ANNUAL COST PER UNIT ASSUMPTIONS.

FOR BUDGET NEUTRALITY DEMONSTRATION IN THE WAIVER APPLICATION, WE HAVE SELECTED TO USE A METHODOLOGY FOR CALCULATION OF FACTOR D' THAT ACCURATELY REFLECTS THE ACUITY OF THE 1915(C) HSW PARTICIPANTS. SPECIFICALLY, FACTOR D' IN THIS REPORT CORRESPONDS TO ACTUAL MEDICAID-COVERED NON-1915(C) EXPENDITURES FOR INDIVIDUALS WHO ARE PARTICIPANTS IN THE HSW. DUE TO THE HIGHER ACUITY FOR THESE INDIVIDUALS, ESPECIALLY WITH REGARD TO BEHAVIORAL HEALTH SERVICES PROVIDED UNDER THE STATE PLAN AND PHARMACY-RELATED EXPENDITURES, FACTOR D' IN THIS REPORT IS GREATER THAN THE CORRESPONDING BEHAVIORAL HEALTH AND PHYSICAL HEALTH CAPITATION RATES, AT THE RATE CELL LEVEL, THAT ARE APPLICABLE TO THESE INDIVIDUALS. HISTORICALLY, FOR CMS 372(S) REPORTING OF FACTOR D', MDHHS HAS RELIED UPON ACTUAL CAPITATION PAYMENTS CORRESPONDING TO THE APPLICABLE RATE CELLS AND MAY CONTINUE TO DO SO. CONSEQUENTLY, DIFFERENCES MAY EXIST BETWEEN FACTOR D' VALUES IN THE 1915(C) WAIVER RENEWAL APPLICATION AND FACTOR D' VALUES IN THE CORRESPONDING CMS 372(S) REPORTING.

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 EXPENDITURES FOR WAIVER YEAR 1 CONTINUE TO BE BASED ON WY4 FROM OHIO'S ICF/IID WAIVER APPLICATION FOR ALL AGES (OH.0380.R04.05) FACTOR G COSTS IN RECOGNITION THAT THE SELECTED OHIO WAIVER IS SIMILAR TO MICHIGAN'S HSW.

FOR WY2 THROUGH WY5, THE AVERAGE COST PER UNIT FOR FACTOR G WAS TRENDED FROM WY1 USING AN ANNUAL TREND RATE OF 3.8% BASED UPON THE THIRD-QUARTER 2024 INPATIENT PSYCHIATRIC FACILITY INPUT PRICE INDEX FROM THE IHS GLOBAL INC. FORECAST RELEASED BY CMS, OACT, NATIONAL HEALTH STATISTICS GROUP, DNHS@CMS.HHS.GOV, ON 04/15/2025. THIS IS A SLIGHT DECREASE FROM THE 4.0% TREND PREVIOUSLY ASSUMED IN THE EXISTING WAIVER RENEWAL APPLICATION.

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' EXPENDITURES FOR WAIVER YEAR 1 CONTINUE TO BE BASED ON WY4 FROM OHIO'S ICF/IID WAIVER APPLICATION FOR ALL AGES (OH.0380.R04.05) FACTOR G' COSTS IN RECOGNITION THAT THE SELECTED OHIO WAIVER IS SIMILAR TO MICHIGAN'S HSW.

FACTOR G' WAS TRENDED AT A RATE OF 3.0% PER YEAR BASED UPON THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS (CPI-U): MEDICAL CARE SERVICES FOR THE PERIOD OF MAY 2024 THROUGH MAY 2025. IT IS IN ALIGNMENT WITH THE COST PER UNIT TREND FOR FACTOR D'.

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	
Out-of-Home Non-Vocational Habilitation	
Respite	
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT	
Enhanced Medical Equipment and Supplies	
Enhanced Pharmacy	
VEHICLE MODIFICATION	
Financial Management Services	
Goods and Services	
Community Living Supports	
Environmental Modifications	
Family Training	
Non-Family Training	
Overnight Health and Safety Support	
Personal Emergency Response System	
Private Duty Nursing	
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Out-of-Home Non-Vocational Habilitation Total:							***21681768.78***
Out-of-Home Non-Vocational Habilitation	☑	*15 minutes*	*1582*	*2319.00*	*5.91*	***21681768.78***	
Respite Total:							***8833520.22***
Respite, out-of-home setting	☑	*Day*				***390052.20***	

GRAND TOTAL: ***690922757.86***

Total: Services included in capitation: *690922757.86*

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: ***8268***

Factor D (Divide total by number of participants): ***83565.89***

Services included in capitation: *83565.89*

Services not included in capitation:

Average Length of Stay on the Waiver: *338*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			149	12.00	218.15		
Respite, in-home setting	☑	Day	97	15.00	249.34	362789.70	
Respite, 15 minutes	☑	15 minutes	1144	1059.00	6.67	8080678.32	
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT Total:							2104433.76
INDIVIDUAL SUPPORTED EMPLOYMENT	☑	15 minutes	341	344.00	17.94	2104433.76	
Enhanced Medical Equipment and Supplies Total:							306675.80
Personal care item, not otherwise specialized	☑	Item	14	4.00	244.21	13675.76	
Durable medical equipment, miscellaneous	☑	Item	90	1.00	1217.93	109613.70	
Specialized medical equipment, not otherwise specified, waiver	☑	Item	103	3.00	513.01	158520.09	
Specialized supply, not otherwise specified, waiver	☑	Item	19	3.00	436.25	24866.25	
Enhanced Pharmacy Total:							709737.60
Enhanced Pharmacy	☑	Item	858	22.00	37.60	709737.60	
VEHICLE MODIFICATION Total:							145533.44
Vehicle modifications, waiver	☑	Item	13	1.00	11194.88	145533.44	
Financial Management Services Total:							3043014.10
Financial Management Services	☑	Month	1981	10.00	153.61	3043014.10	
Goods and Services							878160.96

GRAND TOTAL: 690922757.86

Total: Services included in capitation: 690922757.86

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 8268

Factor D (Divide total by number of participants): 83565.89

Services included in capitation: 83565.89

Services not included in capitation:

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Goods and Services	☑	Item	536	1.00	1638.36	**878160.96**	
Community Living Supports Total:							**575336345.33**
CLS per diem - licensed	☑	Day	4313	311.00	237.53	**318609202.79**	
CLS per 15 minutes	☑	15 minutes	4449	9174.00	6.29	**256727142.54**	
CLS per diem - Non-Licensed Residential	☑	Day	0	0.00	0.01	**0.00**	
Environmental Modifications Total:							**490825.44**
Environmental Modifications	☑	Service	36	1.00	13634.04	**490825.44**	
Family Training Total:							**247515.84**
Family Training	☑	Encounter	132	12.00	156.26	**247515.84**	
Non-Family Training Total:							**175139.36**
Non-Family Training	☑	Encounter	191	8.00	114.62	**175139.36**	
Overnight Health and Safety Support Total:							**63533849.60**
Overnight Health and Safety Support	☑	15 minutes	1508	9080.00	4.64	**63533849.60**	
Overnight Health and Safety Support - per diem	☑	Day	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:							**2717514.17**
PERS monthly monitoring	☑	Month	82	11.00	3009.29	**2714379.58**	
PERS installation & testing	☑	Encounter	1	1.00	3134.59	**3134.59**	
Private Duty Nursing Total:							**9483333.46**
PDN by RN	☑	Hour	48	1501.00	73.82	**5318583.36**	
PDN by LPN	☑	Hour	49	1445.00	58.82	**4164750.10**	

GRAND TOTAL: **690922757.86**

Total: Services included in capitation: 690922757.86

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **8268**

Factor D (Divide total by number of participants): **83565.89**

Services included in capitation: 83565.89

Services not included in capitation:

Average Length of Stay on the Waiver: 338

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT Total:							**1235390.00**
SMALL GROUP EMPLOYMENT	☑	15 minutes	172	845.00	8.50	**1235390.00**	

GRAND TOTAL: 690922757.86
Total: Services included in capitation: 690922757.86
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 8268
Factor D (Divide total by number of participants): 83565.89
Services included in capitation: 83565.89
Services not included in capitation:
Average Length of Stay on the Waiver: 338

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**22936278.96**
Out-of-Home Non-Vocational Habilitation	☑	15 minutes	1582	2346.00	6.18	**22936278.96**	
Respite Total:							**9335267.23**
Respite, out-of-home setting	☑	Day	149	12.00	228.19	**408003.72**	
Respite, in-home setting	☑	Day	97	15.00	260.81	**379478.55**	
Respite, 15 minutes	☑	15 minutes	1144	1072.00	6.97	**8547784.96**	
SUPPORTED EMPLOYMENT-INDIVIDUAL							**2227398.36**

GRAND TOTAL: 755457767.92
Total: Services included in capitation: 683935702.66
Total: Services not included in capitation: 71522065.26
Total Estimated Unduplicated Participants: 8268
Factor D (Divide total by number of participants): 91371.28
Services included in capitation: 82720.82
Services not included in capitation: 8650.47
Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SUPPORTED EMPLOYMENT Total:							
INDIVIDUAL SUPPORTED EMPLOYMENT	☑	15 minutes	341	348.00	18.77	**2227398.36**	
Enhanced Medical Equipment and Supplies Total:							**320783.20**
Personal care item, not otherwise specialized	☑	Item	14	4.00	255.44	**14304.64**	
Durable medical equipment, miscellaneous	☑	Item	90	1.00	1273.96	**114656.40**	
Specialized medical equipment, not otherwise specified, waiver	☑	Item	103	3.00	536.61	**165812.49**	
Specialized supply, not otherwise specified, waiver	☑	Item	19	3.00	456.31	**26009.67**	
Enhanced Pharmacy Total:							**742393.08**
Enhanced Pharmacy	☑	Item	858	22.00	39.33	**742393.08**	
VEHICLE MODIFICATION Total:							**152227.92**
Vehicle modifications, waiver	☑	Item	13	1.00	11709.84	**152227.92**	
Financial Management Services Total:							**3182872.70**
Financial Management Services	☑	Encounter	1981	10.00	160.67	**3182872.70**	
Goods and Services Total:							**918559.28**
Goods and Services	☑	Item	536	1.00	1713.73	**918559.28**	
Community Living Supports Total:							**626301018.91**
CLS per diem - licensed	☑	Day	4313	315.00	248.45	**337542927.75**	
CLS per 15 minutes	☑	15 minutes				**102221436.24**	

GRAND TOTAL: **755457767.92**

Total: Services included in capitation: 683935702.66

Total: Services not included in capitation: 71522065.26

Total Estimated Unduplicated Participants: **8268**

Factor D (Divide total by number of participants): **91371.28**

Services included in capitation: 82720.82

Services not included in capitation: 8650.47

Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			4181	3528.00	6.93		
CLS per diem - Non-Licensed Residential	☑	Day	2983	158.00	395.78	186536654.92	
Environmental Modifications Total:							513403.20
Environmental Modifications	☑	Service	36	1.00	14261.20	513403.20	
Family Training Total:							258904.80
Family Training	☑	Encounter	132	12.00	163.45	258904.80	
Non-Family Training Total:							183191.92
Non-Family Training	☑	Encounter	191	8.00	119.89	183191.92	
Overnight Health and Safety Support Total:							74197431.96
Overnight Health and Safety Support	☑	15 minutes	1033	534.00	4.85	2675366.70	
Overnight Health and Safety Support - per diem	☐	Day	1613	271.00	163.62	71522065.26	
Personal Emergency Response System Total:							2842522.22
PERS monthly monitoring	☑	Month	82	11.00	3147.72	2839243.44	
PERS installation & testing	☑	Encounter	1	1.00	3278.78	3278.78	
Private Duty Nursing Total:							10038150.78
PDN by RN	☑	Hour	48	1519.00	77.22	5630264.64	
PDN by LPN	☑	Hour	49	1462.00	61.53	4407886.14	
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT Total:							1307363.40
SMALL GROUP EMPLOYMENT	☑	15 minutes	172	855.00	8.89	1307363.40	

GRAND TOTAL: 755457767.92

Total: Services included in capitation: 683935702.66

Total: Services not included in capitation: 71522065.26

Total Estimated Unduplicated Participants: 8268

Factor D (Divide total by number of participants): 91371.28

Services included in capitation: 82720.82

Services not included in capitation: 8650.47

Average Length of Stay on the Waiver: 342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**23864121.96**
Out-of-Home Non-Vocational Habilitation	☑	15 minutes	1582	2346.00	6.43	**23864121.96**	
Respite Total:							**9710147.03**
Respite, out-of-home setting	☑	Day	149	12.00	237.31	**424310.28**	
Respite, in-home setting	☑	Day	97	15.00	271.25	**394668.75**	
Respite, 15 minutes	☑	15 minutes	1144	1072.00	7.25	**8891168.00**	
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT Total:							**2316399.36**
INDIVIDUAL SUPPORTED EMPLOYMENT	☑	15 minutes	341	348.00	19.52	**2316399.36**	
Enhanced Medical Equipment and Supplies Total:							**333616.07**
Personal care item, not otherwise specialized	☑	Item	14	4.00	265.66	**14876.96**	
Durable medical equipment, miscellaneous	☑	Item	90	1.00	1324.91	**119241.90**	
Specialized medical equipment, not otherwise	☑	Item	103	3.00	558.08	**172446.72**	

GRAND TOTAL: **785585647.20**

Total: Services included in capitation: 785585647.20

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **8268**

Factor D (Divide total by number of participants): **95015.20**

Services included in capitation: 95015.20

Services not included in capitation:

Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
specified, waiver							
Specialized supply, not otherwise specified, waiver	☑	Item	19	3.00	474.57	27050.49	
Enhanced Pharmacy Total:							772028.40
Enhanced Pharmacy	☑	Item	858	22.00	40.90	772028.40	
VEHICLE MODIFICATION Total:							158317.12
Vehicle modifications, waiver	☑	Item	13	1.00	12178.24	158317.12	
Financial Management Services Total:							3310251.00
Financial Management Services	☑	Encounter	1981	10.00	167.10	3310251.00	
Goods and Services Total:							955296.72
Goods and Services	☑	Item	536	1.00	1782.27	955296.72	
Community Living Supports Total:							651249007.19
CLS per diem - licensed	☑	Day	4313	315.00	258.39	351047362.05	
CLS per 15 minutes	☑	15 minutes	4181	3528.00	7.20	106204089.60	
CLS per diem - Non-Licensed Residential	☑	Day	2983	158.00	411.61	193997555.54	
Environmental Modifications Total:							533939.40
Environmental Modifications	☑	Service	36	1.00	14831.65	533939.40	
Family Training Total:							269248.32
Family Training	☑	Encounter	132	12.00	169.98	269248.32	
Non-Family Training Total:							190526.32
Non-Family Training	☑	Encounter	191	8.00	124.69	190526.32	
Overnight Health and Safety Support							77166540.78

GRAND TOTAL: 785585647.20

Total: Services included in capitation: 785585647.20

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 8268

Factor D (Divide total by number of participants): 95015.20

Services included in capitation: 95015.20

Services not included in capitation:

Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Overnight Health and Safety Support	☑	15 minutes	1033	534.00	5.05	**2785691.10**	
Overnight Health and Safety Support - per diem	☑	Day	1613	271.00	170.16	**74380849.68**	
Personal Emergency Response System Total:							**2956224.19**
PERS monthly monitoring	☑	Month	82	11.00	3273.63	**2952814.26**	
PERS installation & testing	☑	Encounter	1	1.00	3409.93	**3409.93**	
Private Duty Nursing Total:							**10439678.34**
PDN by RN	☑	Hour	48	1519.00	80.31	**5855562.72**	
PDN by LPN	☑	Hour	49	1462.00	63.99	**4584115.62**	
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT Total:							**1360305.00**
SMALL GROUP EMPLOYMENT	☑	15 minutes	172	855.00	9.25	**1360305.00**	

GRAND TOTAL: **785585647.20**
Total: Services included in capitation: 785585647.20
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: **8268**
Factor D (Divide total by number of participants): **95015.20**
Services included in capitation: 95015.20
Services not included in capitation:
Average Length of Stay on the Waiver: 342

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**24903163.74**
Out-of-Home Non-Vocational Habilitation	☑	15 minutes	1582	2353.00	6.69	**24903163.74**	
Respite Total:							**10124425.90**
Respite, out-of-home setting	☑	Day	149	12.00	246.80	**441278.40**	
Respite, in-home setting	☑	Day	97	15.00	282.10	**410455.50**	
Respite, 15 minutes	☑	15 minutes	1144	1075.00	7.54	**9272692.00**	
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT Total:							**2415882.70**
INDIVIDUAL SUPPORTED EMPLOYMENT	☑	15 minutes	341	349.00	20.30	**2415882.70**	
Enhanced Medical Equipment and Supplies Total:							**346960.09**
Personal care item, not otherwise specialized	☑	Item	14	4.00	276.29	**15472.24**	
Durable medical equipment, miscellaneous	☑	Item	90	1.00	1377.91	**124011.90**	
Specialized medical equipment, not otherwise specified, waiver	☑	Item	103	3.00	580.40	**179343.60**	
Specialized supply, not otherwise specified, waiver	☑	Item	19	3.00	493.55	**28132.35**	
Enhanced Pharmacy Total:							**802985.04**
Enhanced Pharmacy	☑	Item	858	22.00	42.54	**802985.04**	
VEHICLE MODIFICATION Total:							**164649.81**
Vehicle modifications,	☑	Item	13	1.00	12665.37	**164649.81**	

GRAND TOTAL: 818962516.27

Total: Services included in capitation: 818962516.27

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 8268

Factor D (Divide total by number of participants): 99052.07

Services included in capitation: 99052.07

Services not included in capitation:

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
waiver							
Financial Management Services Total:							**3442581.80**
Financial Management Services	☑	Encounter	1981	10.00	173.78	**3442581.80**	
Goods and Services Total:							**993508.16**
Goods and Services	☑	Item	536	1.00	1853.56	**993508.16**	
Community Living Supports Total:							**678804562.04**
CLS per diem - licensed	☑	Day	4313	316.00	268.73	**366254266.84**	
CLS per 15 minutes	☑	15 minutes	4181	3538.00	7.49	**110794911.22**	
CLS per diem - Non-Licensed Residential	☑	Day	2983	158.00	428.07	**201755383.98**	
Environmental Modifications Total:							**555297.12**
Environmental Modifications	☑	Service	36	1.00	15424.92	**555297.12**	
Family Training Total:							**280019.52**
Family Training	☑	Encounter	132	12.00	176.78	**280019.52**	
Non-Family Training Total:							**198151.04**
Non-Family Training	☑	Encounter	191	8.00	129.68	**198151.04**	
Overnight Health and Safety Support Total:							**80549971.92**
Overnight Health and Safety Support	☑	15 minutes	1033	536.00	5.25	**2906862.00**	
Overnight Health and Safety Support - per diem	☑	Day	1613	272.00	176.97	**77643109.92**	
Personal Emergency Response System Total:							**3074477.49**
PERS monthly monitoring	☑	Month	82	11.00	3404.58	**3070931.16**	
PERS installation &	☑					**3546.33**	

GRAND TOTAL: **818962516.27**

Total: Services included in capitation: 818962516.27

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **8268**

Factor D (Divide total by number of participants): **99052.07**

Services included in capitation: 99052.07

Services not included in capitation:

Average Length of Stay on the Waiver: 343

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
testing		Encounter	1	1.00	3546.33		
Private Duty Nursing Total:							**10886198.78**
PDN by RN	☑	Hour	48	1523.00	83.52	**6105646.08**	
PDN by LPN	☑	Hour	49	1466.00	66.55	**4780552.70**	
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT Total:							**1419681.12**
SMALL GROUP EMPLOYMENT	☑	15 minutes	172	858.00	9.62	**1419681.12**	

GRAND TOTAL: 818962516.27
Total: Services included in capitation: 818962516.27
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 8268
Factor D (Divide total by number of participants): 99052.07
Services included in capitation: 99052.07
Services not included in capitation:
Average Length of Stay on the Waiver: 343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out-of-Home Non-Vocational Habilitation Total:							**25831149.12**
Out-of-Home Non-Vocational Habilitation	☑	15 minutes	1582	2346.00	6.96	**25831149.12**	
Respite Total:							**10500518.98**
Respite, out-of-	☑					**458925.96**	

GRAND TOTAL: 849747152.04
Total: Services included in capitation: 849747152.04
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 8268
Factor D (Divide total by number of participants): 102775.42
Services included in capitation: 102775.42
Services not included in capitation:
Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
home setting		Day	149	12.00	256.67		
Respite, in-home setting	☑	Day	97	15.00	293.38	426867.90	
Respite, 15 minutes	☑	15 minutes	1144	1072.00	7.84	9614725.12	
SUPPORTED EMPLOYMENT-INDIVIDUAL SUPPORTED EMPLOYMENT Total:							2505081.48
INDIVIDUAL SUPPORTED EMPLOYMENT	☑	15 minutes	341	348.00	21.11	2505081.48	
Enhanced Medical Equipment and Supplies Total:							360839.85
Personal care item, not otherwise specialized	☑	Item	14	4.00	287.34	16091.04	
Durable medical equipment, miscellaneous	☑	Item	90	1.00	1433.03	128972.70	
Specialized medical equipment, not otherwise specified, waiver	☑	Item	103	3.00	603.62	186518.58	
Specialized supply, not otherwise specified, waiver	☑	Item	19	3.00	513.29	29257.53	
Enhanced Pharmacy Total:							835074.24
Enhanced Pharmacy	☑	Item	858	22.00	44.24	835074.24	
VEHICLE MODIFICATION Total:							171235.74
Vehicle modifications, waiver	☑	Item	13	1.00	13171.98	171235.74	
Financial Management Services Total:							3580261.30
Financial Management Services	☑	Encounter	1981	10.00	180.73	3580261.30	
Goods and Services							1033247.20

GRAND TOTAL: 849747152.04

Total: Services included in capitation: 849747152.04

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 8268

Factor D (Divide total by number of participants): 102775.42

Services included in capitation: 102775.42

Services not included in capitation:

Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Goods and Services	☑	Item	536	1.00	1927.70	**1033247.20**	
Community Living Supports Total:							**704431334.98**
CLS per diem - licensed	☑	Day	4313	315.00	279.48	**379700130.60**	
CLS per 15 minutes	☑	15 minutes	4181	3528.00	7.79	**114906924.72**	
CLS per diem - Non-Licensed Residential	☑	Day	2983	158.00	445.19	**209824279.66**	
Environmental Modifications Total:							**577509.12**
Environmental Modifications	☑	Service	36	1.00	16041.92	**577509.12**	
Family Training Total:							**291218.40**
Family Training	☑	Encounter	132	12.00	183.85	**291218.40**	
Non-Family Training Total:							**206081.36**
Non-Family Training	☑	Encounter	191	8.00	134.87	**206081.36**	
Overnight Health and Safety Support Total:							**83464344.27**
Overnight Health and Safety Support	☑	15 minutes	1033	534.00	5.46	**3011856.12**	
Overnight Health and Safety Support - per diem	☑	Day	1613	271.00	184.05	**80452488.15**	
Personal Emergency Response System Total:							**3197453.70**
PERS monthly monitoring	☑	Month	82	11.00	3540.76	**3193765.52**	
PERS installation & testing	☑	Encounter	1	1.00	3688.18	**3688.18**	
Private Duty Nursing Total:							**11291202.30**
PDN by RN	☑	Hour	48	1519.00	86.86	**6333136.32**	
PDN by LPN	☑	Hour	49	1462.00	69.21	**4958065.98**	

GRAND TOTAL: 849747152.04

Total: Services included in capitation: 849747152.04

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 8268

Factor D (Divide total by number of participants): 102775.42

Services included in capitation: 102775.42

Services not included in capitation:

Average Length of Stay on the Waiver: 342

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SUPPORTED EMPLOYMENT-SMALL GROUP EMPLOYMENT Total:							**1470600.00**
SMALL GROUP EMPLOYMENT	☑	15 minutes	172	855.00	10.00	**1470600.00**	

GRAND TOTAL: **849747152.04**

Total: Services included in capitation: 849747152.04

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **8268**

Factor D (Divide total by number of participants): **102775.42**

Services included in capitation: 102775.42

Services not included in capitation:

Average Length of Stay on the Waiver: 342