



## MI CHOICE WAIVER

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## **SECTION 1 - GENERAL INFORMATION**

MI Choice is a waiver program operated by the Michigan Department of Health and Human Services (MDHHS) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria that supports required long-term care (as opposed to rehabilitative or limited term stay) provided in a nursing facility. The waiver is approved by the Centers for Medicare & Medicaid Services (CMS) under section 1915(c) and section 1915(b) of the Social Security Act. MDHHS carries out its waiver obligations through a network of enrolled providers that operate as Prepaid Ambulatory Health Plans (PAHPs). These entities are commonly referred to as waiver agencies. MDHHS and its waiver agencies must abide by the terms and conditions set forth in the waiver.

MI Choice services are available to qualified participants throughout the state, and all provisions of the program are available to each qualified participant unless otherwise noted in this policy and approved by CMS. MDHHS will not enact any provision to the MI Choice program that prohibits or inhibits a participant's access to a person-centered plan of service, discourages participant direction of services, interferes with a participant's right to have grievances and complaints heard, or endangers the health and welfare of a participant. The program must monitor and actively seek to improve the quality of services delivered to participants. Safeguards are utilized to ensure the integrity of payments for waiver services and the adequacy of systems to maintain compliance with federal requirements.

Waiver agencies are required to provide oral and written assistance to all Limited English Proficient applicants and participants. Agencies must arrange for translated materials to be accessible or make such information available orally through bi-lingual staff or through the use of interpreters.



## **SECTION 2 – ELIGIBILITY**

The MI Choice program is available to persons 18 years of age or older who meet each of three eligibility criteria:

- An applicant must establish their financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.
- The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- It must be established that the applicant requires at least two waiver services, one of which must be Supports Coordination, and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met in order to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program.

### **2.1 FINANCIAL ELIGIBILITY [CHANGE MADE 7/1/18]**

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by MDHHS. As a provision of the waiver, MI Choice applicants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is furnished to participants in the special home and community-based group under 42 CFR §435.217 with a special income level equal to 300% of the SSI Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend-down to the income limit to become financially eligible for MI Choice.

To initiate financial eligibility determination, waiver agencies must enter enrollment notifications electronically in CHAMPS. Once the electronic enrollment is completed in CHAMPS, the participant will be assigned an associated MI Choice Program Enrollment Type (PET) code. Waiver agencies must enter disenrollment notifications electronically in CHAMPS to notify MDHHS of participants who are no longer enrolled in MI Choice. Once an electronic disenrollment is completed in CHAMPS, the participant's PET code will end date to reflect a disenrollment date. Proper recordkeeping requirements must be followed and reflected in the applicant's or participant's case record. (revised per bulletin MSA 17-46)

### **2.2 FUNCTIONAL ELIGIBILITY**

The MI Choice waiver agency must verify an applicant's medical/functional eligibility for program enrollment by inputting a valid Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) into the online LOCD application. A valid LOCD is defined as an LOCD that was completed in-person with the applicant according to MDHHS policy and put in the online LOCD application within 14 calendar days after the date of enrollment into the MI Choice program. (Refer to the Directory Appendix for website information.) The LOCD is discussed in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter. Additional information can be found in the Nursing Facility Coverages Chapter and is applicable to MI Choice applicants and participants.

The applicant must also demonstrate a continuing need for and use of at least two covered MI Choice services, one of which must be Supports Coordination. This need is originally established through the



Initial Assessment using the process outlined in the Need for MI Choice Services subsection of this chapter.

## 2.2.A. MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

MI Choice applicants are evaluated for functional eligibility via the Michigan Medicaid Nursing Facility Level of Care Determination. The LOCD is available online through MILogin in CHAMPS. (Refer to the Directory Appendix for website information.)

Applicants must qualify for functional eligibility through one of seven doors. These doors are:

- Door 1: Activities of Daily Living Dependency
- Door 2: Cognitive Performance
- Door 3: Physician Involvement
- Door 4: Treatments and Conditions
- Door 5: Skilled Rehabilitation Therapies
- Door 6: Behavioral Challenges
- Door 7: Service Dependency

The LOCD must be completed in person by a health care professional (physician, registered nurse (RN), licensed practical nurse (LPN), licensed social worker (BSW or MSW), or a physician assistant) or be completed by staff that have direct oversight by a health care professional. The person completing the LOCD must either be waiver agency staff or in the waiver agency's provider network.

The online version of the LOCD must be completed within 14 calendar days after the date of enrollment in MI Choice for the following:

- All new Medicaid-eligible enrollees
- Non-emergency transfers of Medicaid-eligible participants from their current MI Choice waiver agency to another MI Choice waiver agency
- Non-emergency transfers of Medicaid-eligible residents from a nursing facility that is undergoing a voluntary program closure and who are enrolling in MI Choice

Annual online LOCDs are not required, however, subsequent redeterminations, progress notes, or participant monitoring notes must demonstrate that the participant continues to meet the level of care criteria on a continuing basis. If waiver agency staff determines that the participant no longer meets the functional level of care criteria for participation (e.g., demonstrates a significant change in condition), another face-to-face online version of the LOCD must be conducted reflecting the change in functional status. This subsequent redetermination must be noted in the case record and signed by the individual conducting the determination.

Copies of the LOCD for participants must be retained by the waiver agency for a minimum period of six years. This information is also retained in the MDHHS LOCD



database. For individuals who do not meet the LOCD criteria, a paper copy of the LOCD must be retained in the applicant's record for no less than three years.

## **2.2.B. FREEDOM OF CHOICE**

Applicants or their legal representatives must be given information regarding all long-term care service options for which they qualify through the nursing facility LOCD, including MI Choice, Nursing Facility and the Program of All-Inclusive Care for the Elderly (PACE). Qualified applicants may only enroll in one of these long-term care programs at any given time. Nursing facility, PACE, MI Choice, and Adult Home Help services cannot be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options via the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the supports coordinator and the applicant (or their legal representative) seeking services and is to be maintained in the applicant's case record.

## **2.2.C. RETROSPECTIVE REVIEW AND MEDICAID RECOVERY**

MDHHS or its designee will perform retrospective reviews to validate the LOCD as performed by waiver agencies. The waiver agency must submit all supporting medical documentation requested by MDHHS or its designee. If the participant is found to be ineligible for MI Choice, MDHHS will recover all Medicaid payments made for the services rendered during the period of ineligibility. The Retrospective Review process (defined in the Beneficiary Eligibility and Admission Process Section of the Nursing Facility Coverages Chapter) is applicable to MI Choice providers.

Determinations resulting from such retrospective reviews may be appealed by the waiver agency through procedures established by MDHHS.

## **2.3 NEED FOR MI CHOICE SERVICES**

In addition to meeting financial and functional eligibility requirements and to be enrolled in the program, MI Choice applicants must demonstrate the need for a minimum of two covered services, one of which must be Supports Coordination, as determined through an in-person assessment and the person-centered planning process. Applicants must also agree to accept to receive MI Choice services on a regular basis, at least every 30 days.

An applicant cannot be enrolled in MI Choice if their service and support needs can be fully met through the intervention of State Plan or other available services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications.





## **2.3.A. INITIAL ASSESSMENT OF PARTICIPANTS**

The MI Choice program has established the Resident Assessment Instrument – Home Care (iHC) as the approved assessment instrument for assessing the functional status of participants. The MI Choice Intake Guidelines, LOCD, and the iHC are not interchangeable tools. (Documents are available on the MDHHS website. Refer to the Directory Appendix for website information.)

Initial assessments are conducted by teams consisting of a minimum of a registered nurse and a social worker, both of whom are properly licensed by the State of Michigan.

## **2.3.B. REASSESSMENT OF PARTICIPANTS**

Reassessments are conducted by either a properly licensed registered nurse or a social worker, whichever is most appropriate to address the circumstances of the participant. A team approach that includes both disciplines is encouraged whenever feasible or necessary. Reassessments are done in person with the participant at the participant's home.

The supports coordinator documents that the participant continues to meet the nursing facility level of care within the case record, specifying the appropriate "door" through which the participant meets level of care criteria. Reassessments are conducted in person 90 days after the initial assessment, with a reassessment every subsequent 180 days, or sooner upon a significant change in the participant's condition. Supports coordinators track reassessment dates within the waiver agency's information systems. If a supports coordinator determines the participant no longer meets the nursing facility level of care, the supports coordinator initiates program discharge procedures and provides the participant with advance notice and information on appeal rights. A refusal which prevents a redetermination within the 180-day window is cause for termination from the program.



## **SECTION 3 – ENROLLMENT**

MI Choice waiver agencies determine the enrollment dates upon MDHHS financial eligibility verification, and termination dates for each participant for whom they provide waiver services. No applicant shall be granted enrollment status without fully meeting all eligibility requirements. MI Choice applicants require at least two waiver services on a continual basis, one of which must be Supports Coordination, in order to be enrolled in MI Choice. When a potentially eligible applicant cannot be enrolled due to the agency being at capacity, the applicant is placed on a waiting list. Refer to the Waiting Lists subsection for additional information. MDHHS reviews and provides final approval for determinations that result in enrollment, denials or terminations for MI Choice.

### **3.1 GENERAL PROVISIONS OF PARTICIPATION**

There are a number of circumstances that play a role in the eligibility status of MI Choice participants. The following subsections define these impacts.

#### **3.1.A. ENROLLMENT IN MEDICAID HEALTH PLANS AND OTHER PROGRAMS**

A program participant cannot be simultaneously enrolled in both MI Choice and a Medicaid Health Plan, PACE program, or any other §1915(c) waiver. Applicants must choose one program in which they wish to enroll. It is not necessary to either delay MI Choice enrollment or withhold MI Choice services pending the disenrollment process from any of the Medicaid Health Plans.

#### **3.1.B. INSTITUTIONAL STAYS**

There are occasions when a MI Choice participant requires a short-term admission to an institutional setting for treatment. The impact of such an institutional stay is dependent on the type of admission and the length of the stay.

A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of waiver services during the hospital stay to avoid unnecessary or redundant service delivery from the hospital or MI Choice, however, the supports coordinator is not required to remove the participant from MI Choice. A participant who is hospitalized for more than 30 days must have their enrollment terminated.

A participant admitted to a nursing facility for rehabilitation services or for any reason must be removed from MI Choice on the date prior to the nursing facility admission. The individual may be re-enrolled into MI Choice upon discharge from the nursing facility as long as the individual meets eligibility criteria as described in the Eligibility section.





## 3.2 MI CHOICE INTAKE GUIDELINES

The MI Choice Intake Guidelines is a list of questions designed to screen applicants for eligibility and further assessment. Additional probative questions are permissible when needed to clarify eligibility. The MI Choice Intake Guidelines does not, in itself, establish program eligibility. A properly completed MI Choice Intake Guidelines is mandatory for MI Choice waiver agencies prior to placing applicants on a MI Choice waiting list when the agency is operating at its capacity. Individuals who score as Level C, Level D, Level D1 or Level E are those applicants determined potentially eligible for program enrollment and will be placed on the MI Choice waiting list. The date of the MI Choice Intake Guidelines contact establishes the chronological placement of the applicant on the waiting list. The MI Choice Intake Guidelines may be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

When the waiver agency is at capacity, applicants requesting enrollment in MI Choice must either be screened by telephone or in person using the MI Choice Intake Guidelines at the time of their request for proper placement on the waiting list. If a caller is seeking services for another individual, the waiver agency shall either contact the applicant for whom services are being requested or complete the MI Choice Intake Guidelines to the extent possible using information known to the caller. For applicants who are deaf, hearing impaired, or otherwise unable to participate in a telephone interview, it is acceptable to use an interpreter, a third-party in the interview, or assistive technology to facilitate the exchange of information.

As a rule, nursing facility residents who are seeking to transition into MI Choice are not contacted by telephone but rather are interviewed in the nursing facility. For the purposes of establishing a point of reference for the waiting list, the date of the initial nursing facility visit (introductory interview) shall be considered the same as conducting a MI Choice Intake Guidelines, so long as the functional objectives of the MI Choice Intake Guidelines are met. (Refer to the Waiting Lists subsection for additional information.) Specifically, the introductory meeting must establish a reasonable expectation that the applicant will meet the functional and financial eligibility requirements of the MI Choice program within the next 60 days.

Applicants who are expected to be ineligible based on MI Choice Intake Guidelines information may request a face-to-face evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination and financial eligibility criteria. Such evaluations should be conducted as soon as possible, but must be done within 10 business days of the date the MI Choice Intake Guidelines was administered. MI Choice waiver agencies must issue an adverse action notice advising applicants of any and all appeal rights when the applicant appears ineligible either through the MI Choice Intake Guidelines or a face-to-face evaluation.

When an applicant appears to be functionally eligible based on the MI Choice Intake Guidelines but is not expected to meet the financial eligibility requirements, the MI Choice waiver agency must place the applicant on the agency's waiting list if it is anticipated that the applicant will become financially eligible within 60 days. Individuals may be placed on the waiting lists of multiple waiver agencies.

The MI Choice Intake Guidelines is the only recognized tool accepted for telephonic screening of MI Choice applicants and is only accessible to MI Choice waiver agencies. It is not intended to be used for any other purpose within the MI Choice program, nor any other Medicaid program. MI Choice waiver agencies must collect MI Choice Intake Guidelines data electronically using software through the MDHHS contracted vendor.



### 3.3 ENROLLMENT CAPACITY

MI Choice capacity is limited to the number of participants who can be adequately served under the annual legislative appropriation for the program. Enrollment capacity for each individual waiver agency is at the agency's discretion based on available funding and the expected costs of maintaining services to enrolled participants.

Waiver agencies are allocated a specific number of slots each fiscal year based upon legislative appropriation and must manage enrollments within that allocation.

### 3.4 WAITING LISTS

Whenever the number of participants receiving services through MI Choice exceeds the existing program capacity, any screened applicant must be placed on the waiver agency's waiting list. Waiting lists must be actively maintained and managed by each MI Choice waiver agency. The enrollment process for the MI Choice program is not ever actually or constructively closed. The applicant's place on the waiting list is determined by priority category in the order described below. Within each category, an applicant is placed on the list in chronological order based on the date of their request for services. This is the only approved method of accessing waiver services when the waiver program is at capacity.

Each waiver agency must follow these waiting list removal guidelines when removing an applicant from the MI Choice waiting list. A MI Choice waiver agency may remove an applicant from the MI Choice waiting list if the applicant:

- Enrolled in MI Choice;
- Enrolled in another community-based service or program;
- Was admitted to a nursing facility and is no longer interested in MI Choice;
- Died;
- Moved out of state;
- Was not eligible for MI Choice;
- Was no longer interested in or refused MI Choice enrollment; or
- Was unable to be contacted by the waiver agency using all of the following methods:
  - The waiver agency called at least three times with a varied day of week and time of day.
  - If the waiver agency was able to leave a message, the applicant did not return the call within 10 business days.
  - The waiver agency sent a letter to the applicant with a deadline to contact the waiver agency within 12 business days, and the applicant either did not respond or mail was returned.

An Adequate Action Notice must be sent to the applicant no later than the date of removal from the MI Choice waiting list. MI Choice waiver agencies can obtain a template for the Adequate Action Notice on the MDHHS website. (Refer to the Directory Appendix for website information.)



### **3.4.A. PRIORITY CATEGORIES**

Applicants will be placed on a waiting list by priority category and then chronologically by date of request of services. Enrollment in MI Choice is assigned on a first-come/first-served basis using the following categories, listed in order of priority given.

Waiver agencies are required to conduct follow-up phone calls to all applicants on their waiting list. The calls are to determine the applicant's status, offer assistance in accessing alternative services, identify applicants who should be removed from the list, and identify applicants who might be in crisis or at imminent risk of admission to a nursing facility. Each applicant on the waiting list is to be contacted at least once every 90 days. Applicants in crisis or at risk require more frequent contacts. Each waiver agency is required to maintain a record of these follow-up contacts.

#### **3.4.A.1. CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS) AGE EXPIRATIONS**

This category includes only those applicants who continue to require Private Duty Nursing services at the time such coverage ends due to age restrictions under CSHCS.

#### **3.4.A.2. NURSING FACILITY TRANSITIONS**

Nursing facility residents who desire to transition to the community and will otherwise meet enrollment requirements for MI Choice qualify for this priority status and are eligible to receive assistance with supports coordination, transition activities, and transition costs. Priority status is not given to applicants whose service and support needs can be fully met by existing State Plan services.

#### **3.4.A.3. ADULT PROTECTIVE SERVICES (APS) AND DIVERSIONS**

An applicant with an active Adult Protective Services (APS) case is given priority when critical needs can be addressed by MI Choice services. It is not expected that MI Choice waiver agencies solicit APS cases, but priority is given when necessary.

An applicant is eligible for diversion priority if they are living in the community or are being released from an acute care setting and are found to be at imminent risk of nursing facility admission. Imminent risk of placement in a nursing facility is determined using the Imminent Risk Assessment (IRA), an evaluation developed by MDHHS. Use of the IRA is essential in providing an objective differentiation between those applicants at risk of a nursing facility placement and those at imminent risk of such a placement. Only applicants found to meet the standard of imminent risk are given priority status on the waiting list. Applicants may request that a subsequent IRA be performed upon a change of condition or circumstance.

Supports coordinators must administer the IRA in person. The design of the tool makes telephone contact insufficient to make a valid determination. Waiver agencies must submit a request for diversion status for an applicant to MDHHS. A final approval of a diversion request is made by MDHHS.



#### **3.4.A.4. CHRONOLOGICAL ORDER BY SERVICE REQUEST DATE**

This category includes applicants who do not meet any of the above priority categories or for whom prioritizing information is not known. As stated, applicants will be placed on the waiting list in the chronological order that they requested services as documented by the date of MI Choice Intake Guidelines completion or initial nursing facility introductory meeting.

#### **3.5 ENROLLMENT SLOTS**

CMS approves a given number of enrollment slots for the MI Choice program in the waiver application process. A slot consists of the enrollment of a participant for the duration of the fiscal year or, in other words, the total number of slots used is an unduplicated count of participants for the fiscal year. Therefore, a participant who might be enrolled and disenrolled from MI Choice numerous times throughout a given fiscal year utilizes only a single slot. Similarly, a participant might be disenrolled from the program at any given time, yet continues to occupy a slot until the conclusion of the fiscal year. It is an important distinction between that which constitutes enrollment and what is counted as a slot. Having a slot does not infer current enrollment.



## **SECTION 4 – SERVICES**

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the current assessment;
- detailed in the plan of service; and
- provided in accordance with the provisions of the approved waiver.

Services must not be provided unless they are defined in the plan of service and must not precede the establishment of a plan of service. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider.

MDHHS and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby assuring freedom of choice.

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

### **4.1 COVERED WAIVER SERVICES**

In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections.

#### **4.1.A. ADULT DAY HEALTH**

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

Transportation between the participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does



not offer transportation or does not offer it to the participant's residence, then MI Choice would pay for the transportation to and from the Adult Day Health center separately.

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

#### **4.1.B. RESPITE**

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

Services include:

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

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

#### **4.1.C. SUPPORTS COORDINATION**

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

Supports coordinators perform the following functions:

- Conduct the initial and subsequent Nursing Facility Level of Care Determinations per state policy. Refer to the Functional Eligibility subsection for additional information.
- Conduct the initial Resident Assessment Instrument – Home Care assessment and periodic reassessments.





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- Facilitate a person-centered planning process that is focused on the participant's preferences; includes family and other allies as determined by the participant; identifies the participant's goals, preferences and needs; provides information about options; and engages the participant in monitoring and evaluating services and supports.
- Assist the participant with developing a plan of service using the person-centered planning process, including revisions to the plan of service at the participant's initiation or as changes in the participant's circumstances may warrant.
- Referral to, and coordinate with, providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or access to legal representation.
- Monitor MI Choice waiver services and other services and supports necessary for achievement of the participants goals. Monitoring includes opportunities for the participant to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.
- Provide social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.
- Provide advocacy in support of the participant's access to benefits, assuring the participant's rights as a program beneficiary, and supporting the participant's decisions.
- Maintain documentation of the above-listed activities to ensure successful support of the participant, comply with Medicaid and other applicable policies, and meet the performance requirements delineated in the waiver agency's contract with MDHHS.

Additional guidance for Supports Coordination is located in the contract between MDHHS and MI Choice waiver agencies which is available online. (Refer to the Directory Appendix for website information.) In addition to requiring and accepting Supports Coordination services, applicants must also require and agree to accept one additional MI Choice service which is needed by the applicant every 30 calendar days in order to qualify for the program.

#### **4.1.D. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES**

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

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



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

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

#### **4.1.E. FISCAL INTERMEDIARY**

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

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

#### **4.1.F. GOODS AND SERVICES**

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

- decrease the need for other Medicaid services,
- promote inclusion in the community, and
- increase the participant's safety in the home environment.

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



Goods and Services are only approved by CMS for participants choosing the self-determination option. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the individual plan of services.

#### **4.1.G. CHORE SERVICES**

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

#### **4.1.H. COMMUNITY LIVING SUPPORTS**

Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in community settings. CLS include assistance to enable participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an ongoing basis when participating in self-determination options. Tasks related to ensuring safe access and egress to the residence are authorized only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant. Transportation to medical appointments is covered by Medicaid through MDHHS.

CLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in household activities, ADL, or routine household care and maintenance.
- Reminding, cueing, observing and/or monitoring of medication administration.
- Assistance, support and/or guidance with such activities as:
  - Non-medical care (not requiring nurse or physician intervention) – assistance with eating, bathing, dressing, personal hygiene, and ADL;
  - Meal preparation, but does not include the cost of the meals themselves;
  - Money management;
  - Shopping for food and other necessities of daily living;



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- Social participation, relationship maintenance, and building community connections to reduce personal isolation;
  - Training and/or assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work;
  - Transportation (excluding to and from medical appointments) from the participant’s residence to community activities, among community activities, and from the community activities back to the participant’s residence; and
  - Routine household cleaning and maintenance.
- Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual’s person-centered plan.
  - Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
  - Observing and reporting any change in the participant’s condition and the home environment to the supports coordinator.

These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.

CLS services cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere. The distinction must be apparent by unique hours and units in the approved service plan.

### 4.1.I. COMMUNITY TRANSITION SERVICES

Community Transition Services (CTS) are non-recurrent expenses for participants transitioning from a nursing facility to a community setting. Allowable transition costs include the following:

|   |  |
|---|--|
| <b>Housing or Security Deposits</b>               | A one-time expense to secure housing or obtain a lease.  |
| <b>Utility Hook-ups and Deposits</b>              | A one-time expense to initiate and secure utilities (television and internet are not included).  |
| <b>Furniture, Appliances, and Moving Expenses</b> | One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are not included). |
| <b>Cleaning</b>                                   | A one-time cleaning expense to assure a clean environment, including pest eradication, allergen control, and over-all cleaning.        |
| <b>Coordination and Support Services</b>          | To facilitate transitioning of participant to a community setting.   |



|              |   |
|--------------|---|
| <b>Other</b> | Services deemed necessary and documented within the participant's plan of service to accomplish the transition into a community setting. Costs for CTS are billable upon enrollment into the MI Choice program. |
|--------------|---|

CTS do not include monthly housing rental or mortgage expense, regular utility charges, or items that are intended for purely diversional and recreational purposes. Additional limitations on the amount, frequency, or duration of services are identified in the contract between the waiver agencies and MDHHS.

#### **4.1.J. COUNSELING**

Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation.

Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral health needs.

#### **4.1.K. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS**

Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's plan of service that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization.

Adaptations may include:

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

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



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The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet the participant's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing.

Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a participant's home.

The waiver agency must assure there is a signed contract or bid proposal with the builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the waiver agency to work with the participant and builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. All services must be provided in accordance with applicable state or local building codes.

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

The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The participant, with the direct assistance of the waiver agency's supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants. The participant's case record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. The MI Choice program is a funding source of last resort.

Adaptations may be made to rental properties when the lease or rental agreement does not indicate the landowner is responsible for such adaptations and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the waiver agency must specify any requirements for restoration of the property to its original condition if the occupant moves.

Excluded are those adaptations or improvements to the home that:

- Are of general utility
- Are considered to be standard housing obligations of the participant or homeowner
- Are not of direct medical or remedial benefit

Examples of exclusions include, but are not limited to,:

- Carpeting
- Roof repair





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- Sidewalks and driveways
- Heating
- Central air conditioning (except under exceptions noted in the service definition)
- Garages and raised garage doors
- Storage and organizers
- Hot tubs, whirlpool tubs, and swimming pools
- Landscaping
- General home repairs

MI Choice does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. MI Choice funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the MI Choice program may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.

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

#### **4.1.L. HOME DELIVERED MEALS**

Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets as indicated in the participant's plan of service. A Home Delivered Meal cannot constitute a full nutritional regimen.

Limitations on who can get a meal include:

- The participant must be unable to obtain food or prepare complete meals.
- The participant does not have an adult living at the same residence or in the vicinity who is able and willing to prepare all meals.



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- The participant does not have a paid caregiver who is able and willing to prepare meals for the participant.
- The provider can appropriately meet the participant's special dietary needs, and the meals available will not jeopardize the participant's health.
- The participant must be able to feed himself/herself.
- The participant must agree to be home when meals are delivered, or contact the program when an absence is unavoidable.

#### **4.1.M. NON-EMERGENCY MEDICAL TRANSPORTATION**

NEMT is defined in 42 CFR 431.53 and 42 CFR 440.170 and includes expenses for transportation and other related travel expenses determined necessary to secure medical examinations, documentation, or treatment for a MI Choice participant.

Waiver agencies will ensure MI Choice participants have access to NEMT as needed to obtain medical services. Utilization of family, friends, or community agencies who provide transportation services without charge must be explored before MI Choice will authorize NEMT. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing NEMT through the MI Choice program.

NEMT includes, but is not limited to, transportation to obtain the following medical services:

- Chronic and ongoing treatment,
- Prescriptions,
- Medical supplies and devices,
- One time, occasional and ongoing visits for medical care, and
- Services received at a Veterans Affairs hospital.

Travel expenses related to the provision of NEMT include:

- The cost of transportation for the MI Choice participant by wheelchair vans, taxis, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation;
- Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant;
- The cost of meals and lodging en route to and from medical care, and while receiving medical care;
- The cost of an attendant to accompany the MI Choice participant, if necessary;
- The cost of the attendant's transportation, meals, and lodging; and



- The attendant's salary, if the attendant is not a volunteer or a member of the MI Choice participant's family.

NEMT provider standards differ from other waiver service provider standards and will be outlined in the contract between MDHHS and waiver agencies.

#### **4.1.N. NON-MEDICAL TRANSPORTATION**

Non-Medical Transportation services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the individual plan of services. Whenever possible, family, neighbors, friends, or community agencies who can provide transportation services without charge must be utilized before MI Choice provides transportation services.

When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health), there must be mechanisms to prevent the duplicative billing of Non-Medical Transportation services.

#### **4.1.O. NURSING SERVICES**

Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home. These services are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of an RN. Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or third party payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant, such as hospitalizations and nursing facility admissions. MI Choice Nursing Services shall not duplicate services available through the Medicaid State Plan or third party resources.

When the participant's condition is unstable, could easily deteriorate, or significantly changes, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health care professional to prevent additional decline, illness, or injury to the participant. The supports coordinator shall communicate with both the nurse providing this service and the participant's health care professional to assure the nursing needs of the participant are being addressed.

Participants must meet at least one of the following criteria to qualify for this service:

- Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
- Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.



- Require professional assessment of the participant's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
- Require professional evaluation of the participant's success with a prescribed exercise routine to assure its effectiveness and identify the need for additional instruction or modifications when necessary.
- Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes.
- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the participant's physician or other health care professional.

In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)).
- Setting up medications according to physician orders.
- Monitoring participant's adherence to their medication regimen.
- Applying dressings that require prescribed medications and aseptic techniques.
- Providing refresher training to the participant or informal caregivers to assure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing ADL, or safe ambulation within the home.

This service is limited to no more than two hours per visit. Participants receiving Private Duty Nursing services are not eligible to receive MI Choice Nursing Services.

#### **4.1.P. PERSONAL EMERGENCY RESPONSE SYSTEM**

A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided. PERS does not cover monthly telephone charges associated with phone service.

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



## 4.1.Q. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN includes the provision of nursing assessment, treatment, and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's plan of service. To be eligible for PDN services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's plan of service must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his/her care and summon assistance.

PDN for a participant between the ages of 18-21 is covered under the Medicaid State Plan.

**Medical Criteria I** – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical rate-dependent ventilation (four or more hours per day) or assisted rate-dependent respiration (e.g., some models of bi-level positive airway pressure); 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 P02 level is 55 mm HG or below.

**Medical Criteria II** – Frequent episodes of medical instability within the past three to six months requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.



## Definitions of Medical Criteria II:

- “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 who is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition.
- “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- “Directly related to the physical disorder” means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL.
- “Substantiated” means documented in the clinical or medical record, including the nursing notes.

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

## Definitions of Medical Criteria III:

- “Continuous” means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- “Skilled nursing” means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to,:
  - Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions.
  - Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day.
  - Deep oral (past the tonsils) or tracheostomy suctioning.





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- 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.
  - Participants receiving MI Choice Nursing Services are not eligible to receive Private Duty Nursing services.
- Where applicable, the participant must use Medicaid State Plan, Medicare, or third party payers first.
  - The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.
  - It is not the intent of the MI Choice program to provide PDN services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDHHS.
  - 24/7 PDN services cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis.
  - All PDN services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria set forth in this chapter.
  - The participant's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the waiver agency and provider agency to assure services are delivered according to that order.



## 4.1.R. TRAINING

Training services consist of instruction provided to a MI Choice participant or caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's plan of service. Training is covered for areas such as activities of daily living, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, Training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision, or other areas related to self-direction.

## 4.2 STATE PLAN SERVICES

MI Choice services are designed to address the unique needs and circumstances of program participants. Some waiver services appear to be the same as services offered in the State Plan; however, they differ in terms of key elements, such as scope of coverage or provider qualifications. Inasmuch as waiver services are designed to meet the specific demands of participants, it is expected that a waiver service will be more appropriate for a participant than a similar State Plan service. Under no circumstances shall the participant receive both services. Waiver agencies cannot authorize payment for services that are offered under the State Plan.

## 4.3 HOSPICE

MI Choice participants may receive State Plan-covered hospice services while participating in MI Choice. Participants must meet all hospice eligibility requirements outlined in the Hospice Chapter. If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services.

State Plan Hospice services must be used to the fullest extent before similar MI Choice services are authorized. Inappropriate services (e.g., duplicative, non-covered) are subject to MDHHS recovery of the amounts paid for those services from the waiver agency.

A joint plan of service for Hospice and MI Choice must be developed and maintained by both the waiver agency and the hospice provider. It is important that the waiver agency understand the hospice philosophy so the two entities work for a common goal and avoid redundant services. Ongoing communication and coordination must occur between the MI Choice supports coordinator and the hospice provider during the time they are serving the participant. Written documentation of this communication and coordination must be kept in the participant's record at each agency.

## 4.4 MEDICATION ADMINISTRATION

Medication administration in MI Choice is established through the provision of Nursing Services.



## 4.5 OPERATING STANDARDS

MDHHS maintains and publishes the "Minimum Operating Standards for MI Choice Waiver Program Services" (known as the Minimum Operating Standards) document. This document defines both general and specific operating criteria for the program. All waiver agencies and service providers are subject to the standards, definitions, limits, and procedures described therein.

For each service offered in MI Choice, the Minimum Operating Standards are used to set the minimum qualifications for all direct service providers, including required certifications, training, experience, supervision, and applicable service requirements. Billing codes and units are also defined in the document.

## 4.6 SERVICES IN LICENSED SETTINGS

Licensing rules for residential setting providers reflect an attempt to make residing in these settings much like it would be in a home. Providers of licensed residential settings must meet the standard of providing a non-institutional setting licensed by the State of Michigan. For further details on what constitutes a home and community-based setting, refer to 42 CFR §441.530.



## **SECTION 5 - NURSING FACILITY TRANSITIONS**

The process of transitioning nursing facility residents to a home or a community-based setting is a priority of MI Choice. The tenet of rebalancing the spectrum of long-term care services in Michigan was given impetus by the 1999 United States Supreme Court decision in *Olmstead v. L. C.*. MDHHS provides mechanisms to ensure an individual resides in the most independent setting.

### **5.1 TRANSITION CANDIDATES**

Initial transition work begins prior to enrollment into the MI Choice program and often occurs before the verification of Medicaid eligibility. Candidates for Community Transition Services are nursing facility residents who have expressed a preference to live at home or in a community-based setting and who have barriers to transitioning that cannot be addressed through standard discharge procedures available to nursing facility staff. Nursing facilities are not relieved of their required discharge planning activities.

### **5.2 TRANSITION SERVICES**

Transition services are one-time expenses necessary to assist a nursing facility resident in moving to a home or similar community setting. Examples of transition services that the waiver agency could provide are in the Services section of this chapter.

**Community Transition Services are not intended to provide assistance in relocating from communal settings such as, but not limited to, adult foster care (AFC) homes, Homes for the Aged (HFAs), assisted living arrangements, or apartments to another home or home-like setting.**

The MI Choice waiver agency must work with the nursing facility resident to develop a transition plan that includes all projected transition costs. The plan must be based on individual goals and needs and must be included in the nursing facility resident's MI Choice record. It must be updated to reflect any changes.

For the contract period, MDHHS will reimburse the waiver agency for prudent and allowable transition expenses and supports coordination costs in accordance with Nursing Facility Transition Guidelines. As specified in the contract between MDHHS and the waiver agency, the waiver agency must notify MDHHS of its intention to transition a nursing facility resident to the MI Choice program when initiating a nursing facility transition plan. Procedures for notification are obtained from the MI Choice program contract manager. (Refer to the Directory Appendix for additional information.) The waiver agency must demonstrate the nursing facility resident has a Medicaid application pending with MDHHS or has been approved for Medicaid and meets MI Choice program criteria. Once the participant is enrolled in the MI Choice program, MDHHS will issue payment to the waiver agency for CTS. Non-waiver nursing facility transition funding is available for those who do not enroll in the MI Choice program upon transition or do not transition.



## **SECTION 6 - SUPPORTS COORDINATION**

Supports coordination facilitates access to, and arrangement of, services and support needed and chosen by MI Choice participants. These are detailed and documented in the participant's plan of service. Refer to the Supports Coordination service description in the Services section of this chapter for additional information.

Supports coordinators use a person-centered approach in working with a participant to determine how their needs will be met. Supports coordinators also monitor the quality of services received and explore other funding options and service opportunities when personal goals exceed the scope of available MI Choice services. For participants choosing the self-determination option for service delivery, the supports coordinator assists in the selection, coordination, and management of those services and providers.

MDHHS includes a Supports Coordination Service Performance Standards document as an attachment to all waiver agency provider contracts. The document prescribes acceptable standards and protocols for the provision of supports coordination services. It is reviewed and amended as necessary.

### **6.1 PERSON-CENTERED PLANNING**

Person-centered planning (PCP) is a process for planning and supporting a participant receiving services that builds on the participant's desire to engage in lawful activities that promote community life and that honor the participant's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the participant desires or requires. Waiver agencies and direct service providers must utilize a PCP process, informing the participant of service options in ways that are meaningful. This includes assessing the needs and desires of the participant, developing service and support plans, and continuously updating and revising those plans as needs and desires change. The participant and their chosen representative(s) must be provided with written information from the waiver agency detailing the right to participate in the PCP process. Waiver agencies and direct service providers implement PCP in accordance with the MDHHS Person-Centered Planning Guideline document that is an attachment to the waiver agency provider contract.

PCP meetings are conducted when the participant is not in crisis and at a time of the participant's choice. The participant has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process. An interim plan of service may be developed by the supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the participant is not ready to fully participate in PCP. Interim care plans are authorized for no more than 30 days without a follow-up visit (or planning meeting) to determine the participant's status.

### **6.2 PLAN OF SERVICE**

The participant's plan of service is an individualized, comprehensive document developed by the participant, their chosen representative(s), and the supports coordinator prior to the provision of services. Using a person-centered process, waiver agencies must establish a written plan of service for each participant that identifies the participant's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. This document includes all services provided to, or needed by, the participant regardless of funding source. The plan of service is developed before MI Choice services are provided. The participant must approve all services and interventions before implementation and the waiver agency



must document participant approval. MI Choice services must be stipulated in the PCP planning process and the participant assessment.

The participant's plan of service contains at a minimum:

- Issues, problems and concerns identified during participant (re)assessment
- Goals for each issue, problem and concern or reason for omission from the plan
- Planned interventions for each goal
- Desired outcome for each intervention
- Participant's agreement to the plan
- A process for reviewing progress toward meeting goals and outcomes of the interventions in place
- The type of service(s) to be provided, including both MI Choice services and from other sources
- The frequency and duration of each service
- The type of provider to furnish each service

### 6.3 SELF-DETERMINATION

Self-Determination provides MI Choice participants the option to direct and control their own waiver services. Not all MI Choice participants choose to participate in self-determination. For those that do, the participant (or chosen representative(s)) has decision-making authority over staff who provide waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring (co-employer)
- Selecting staff from worker registry
- Hiring staff (common law employer)
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the participant's needs and preferences so long as such qualifications are consistent with the qualifications specified in the approved waiver application and the Minimum Operating Standards
- Specifying how services are to be provided and determining staff duties consistent with the service specifications in the approved waiver application and the Minimum Operating Standards
- Determining staff wages and benefits, subject to State limits (if any)
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance





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- Verifying time worked by staff and approving timesheets
- Discharging staff (common law employer)
- Discharging staff from providing services (co-employer)
- Reallocating funds among services included in the participant's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Participant budget development for participants in self-direction occurs during the person-centered planning process and is intended to involve individuals the participant chooses. Planning for the participant's plan of service precedes the development of the participant's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. A participant's budget is not authorized until both the participant and the waiver agency have agreed to the amount and its use. In the event that the participant is not satisfied with the authorized budget, he/she may reconvene the person-centered planning process. The waiver services of Fiscal Intermediary and Goods and Services are available specifically to self-determination participants to enhance their abilities to more fully exercise control over their services.

The participant may, at any time, modify or terminate the arrangements that support self-determination. The most effective method for making changes is the person-centered planning process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may be interfering with the success of a self-determination arrangement. The decision of a participant to terminate participation in self-determination does not alter the services and supports identified in the participant's plan of service. When the participant terminates self-determination, the waiver agency has an obligation to assume responsibility for assuring the provision of those services through its network of contracted provider agencies.

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



## **SECTION 7 - ADMINISTRATION**

MDHHS serves as the single state agency in the operation of the MI Choice program. MDHHS contracts with entities to administer the program throughout the state. Certain administrative functions are assigned to the local agencies as defined in the Medicaid waiver application to CMS, as renewed and amended. To assist MDHHS in operating MI Choice, agencies are required to submit periodic reports as detailed in this section.

### **7.1 WAIVER AGENCIES AS PREPAID AMBULATORY HEALTH PLANS**

MDHHS contracts with waiver agencies that operate as Prepaid Ambulatory Health Plans (PAHPs) to perform administrative functions. They are responsible for disseminating waiver information to applicants, assisting applicants with waiver enrollment (which includes assisting applicants with completion of the Medicaid Assistance Application (DHS-1171) to secure financial eligibility), managing waiver enrollment against approved limits, monitoring expenditures against approved limits, conducting assessments and LOCD evaluations, reviewing participant plans of service to ensure that waiver requirements are met, conducting utilization reviews and quality management reviews, recruiting providers, and executing Medicaid provider agreements.

Each waiver agency must sign a provider contract with MDHHS assuring that it meets all program requirements.

Waiver agencies are responsible for securing qualified service providers to deliver services. Eligible provider applicants include public, private non-profit or for-profit organizations that provide services meeting established service standards, certifications or licensure requirements. Participants may only use providers in the waiver agency's provider network.

### **7.2 WAITING LIST REPORTING**

Waiting list data is collected and maintained on a secure, web-based application. Waiver agencies must complete all required fields for each qualified MI Choice applicant. Waiting list data must be entered online within one business day after completion of the MI Choice Intake Guidelines. If an applicant is removed from the MI Choice waiting list, the data must be completed online within five business days and include the reason for removal.

### **7.3 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

All MI Choice waiver agencies and providers are required to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any subsequent revisions. Compliance is required in areas that include privacy and security rules, data sharing, and disclosure.



## **SECTION 8 - FINANCING AND REIMBURSEMENT**

Annual funding levels for MI Choice are subject to appropriation allocations made by the Michigan Legislature. MDHHS contracts annually with waiver agencies to operate the MI Choice program and all waiver agency budget and reimbursement requirements and considerations must be defined in the contract, as amended. Any additional consideration or compensation to the waiver agency must also be included in the annual contract, as amended. Waiver agencies are paid through capitation payments and are required to submit all encounter data to MDHHS as outlined in the Encounter Reporting subsection of this chapter. Encounter data is processed through the Community Health Automated Medicaid Processing System (CHAMPS). Waiver agencies are required to submit all financial reports as detailed in the annual contract. Each agency is subject to review or audit by MDHHS, the State of Michigan, or their designee.

### **8.1 REIMBURSEMENT SCHEDULE**

At the end of each month, MDHHS will run the 834 Enrollment file for each waiver agency. This file contains an electronic listing of individuals who are enrolled in the MI Choice program with each provider. The Medicaid Management Information System (MMIS) then performs quality checks, including:

- Verification of current Medicaid eligibility;
- A valid LOCD indicating the participant meets nursing facility level of care; and
- The participant is not enrolled in any other long-term care program.

On the fourth pay cycle of each month, the 820 premium payment will run and will electronically transfer the appropriate per member per month capitation payment for each participant enrolled with each waiver agency.

### **8.2 SPECIAL SERVICES**

MDHHS may arrange special service structures that extend beyond the standard contract language to address special circumstances that arise.

#### **8.2.A. GAP-FILLING SERVICES**

Waiver agencies may authorize services for waiver participants to address situations that require immediate attention to alleviate barriers crucial to the participant's independence when no other resources, including waiver services, are available to address such needs. These are referred to as gap-filling services and are to be included in the participant's plan of service. Gap-filling services must also be included in encounter data submitted to MDHHS.

#### **8.2.B. TEMPORARILY INELIGIBLE PARTICIPANT (TIP) SERVICES**

Waiver agencies may authorize services for temporarily ineligible participants (TIP). TIP services are necessary to sustain a participant through a temporary period of ineligibility. TIP services are included in the participant's plan of service and the reason such services are necessary must be documented by the waiver agencies. TIP services must be included in encounter data submitted to MDHHS. TIP services for any given participant



are limited to a cumulative total of no more than three months per calendar year unless prior approval is obtained from MDHHS.

### **8.3 ENCOUNTER DATA REPORTING**

Medicaid is established as the payer of last resort. Waiver agencies must pursue and secure all third party liability (TPL) sources possible. Agencies must make every effort to enroll and utilize dually certified (Medicare and Medicaid) providers. Agencies cannot use waiver funds for services that are covered through another payment source.

Each waiver agency must submit all encounter data to MDHHS within 180 calendar days of the date that services were rendered. Waiver agencies must resolve issues related to encounters that are rejected by CHAMPS within 30 calendar days of notification by MDHHS or its designee. Agencies have 10 calendar days after the expiration of the 30-day resolution window to report on issues that cannot be resolved.

### **8.4 ADMINISTRATIVE EXPENSE AND OTHER FINANCIAL REPORTING**

Each waiver agency shall submit an Administrative Expense Report (AER) to MDHHS as specified in the contract. The expenses reported must be actual expenses incurred by the waiver agency. Each AER shall cover one calendar month and is due within 30 calendar days after the conclusion of that month. Waiver agencies must submit additional financial reports and information as requested by MDHHS. MDHHS must communicate requirements for such additional information to the waiver agency in writing and allow sufficient time for a response.

### **8.5 FINANCIAL AUDIT REQUIREMENTS**

MI Choice waiver agencies are contractually obligated to comply with, and assure compliance by, its subcontractors with all requirements of the Single Audit Act and any amendments to this act. Waiver agencies must submit to MDHHS a Single Audit, Financial Statement Audit, or Audit Status Notification Letter. If submitting a Single Audit or Financial Statement Audit, waiver agencies must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs and a management letter (if issued) with a response.

Waiver agencies that expend \$500,000 or more in federal awards during the agency's fiscal year must submit to MDHHS a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and F.

Waiver agencies exempt from the Single Audit requirements that receive \$500,000 or more in total funding from MDHHS in state and federal grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with Generally Accepted Auditing Standards (GAAS). Waiver agencies exempt from the Single Audit requirements that receive less than \$500,000 of total MDHHS grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that negatively impact MDHHS-funded programs including, but not limited to, fraud, financial statement misstatements, and violations of contract and grant provisions.

Waiver agencies exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template



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for the Audit Status Notification Letter and further instructions are available on the MDHHS website. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

The required audit and any other required submissions (i.e., Corrective Action Plan and management letter with a response, or Audit Status Notification Letter) must be submitted within nine months following the end of the contractor's fiscal year to the MDHHS Office of Audit, Quality Assurance and Review Section. (Refer to the Directory Appendix for contact information.)

Waiver agencies and each of their contractors are subject to the provisions of, and must comply with, the cost principles set forth in OMB Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and E.



## **SECTION 9 – PROVIDERS**

Authorization for provision of services is the responsibility of the waiver agencies. They determine the status of the qualifications and certifications (if applicable) for all direct service providers, negotiate and enter into contracts with the providers, and reimburse providers.

### **9.1 ENROLLMENT OF SERVICE PROVIDERS**

Waiver agencies must use written contracts meeting the requirements of 42 CFR 434.6 to purchase services. Entities or individuals under subcontract with the waiver agencies must meet provider standards defined in the Minimum Operating Standards for MI Choice Waiver Program Services which is maintained by MDHHS and attached to each annual waiver agency contract. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

To assure network capacity, as well as choice of providers, each waiver agency must have a provider network with capacity to service at least 125% of their monthly slot utilization for each MI Choice service and at least two providers for each MI Choice service. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from MDHHS.

### **9.2 FAMILY MEMBERS AS SERVICE PROVIDERS**

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify his/her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the plan of service and authorized by the supports coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the plan of service, the supports coordinator must rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

### **9.3 REIMBURSEMENT RATES FOR PROVIDERS**

Each waiver agency is responsible for sub-contracting with provider entities and for assuring access to services. The process of rate determination for providers resides in the contract negotiation between the waiver agency and the provider. MDHHS does not play a role in this process.

Rates paid for services provided through the waiver must be adequate to assure access to services needed by participants.

MDHHS does not make payment to legally responsible individuals for furnishing Community Living Supports or similar services.





## 9.4 CRIMINAL HISTORY REVIEWS

Each waiver agency and direct provider of home-based services must conduct a criminal history review through the Michigan State Police for each paid staff or volunteer who will be entering a participant's residence. The waiver agency and direct provider shall have completed reference and criminal history checks before authorizing an employee or volunteer to furnish services in a participant's residence. The scope of the investigation is statewide.

Both waiver agencies and MDHHS conduct administrative monitoring reviews of providers annually to verify that mandatory criminal history checks have been conducted in compliance with operating standards. Waiver agencies must comply with additional criminal history reviews mandated by the State for home and community-based services providers.

## 9.5 USE OF RESTRAINTS, SECLUSION OR RESTRICTIVE INTERVENTIONS

Providers are prohibited from using seclusion or restrictive interventions in addition to using restraints. Qualified reviewers conduct Clinical Quality Assurance Reviews and home visits which include a discovery process to examine the use of restraints, seclusion or restrictive interventions by family or caregivers. Supports coordinators have the primary responsibility for identifying and addressing the use of restraints, seclusion or restrictive interventions.



## **SECTION 10 - PROGRAM QUALITY**

The process of ensuring the highest quality program involves a continuous cycle of discovery, intervention, and evaluation. MDHHS is resolute about assuring and improving the quality of services and protections it provides. To assure that level of service, MDHHS operates a comprehensive quality management system that incorporates reviews of the administrative operations of the waiver agencies, clinical reviews of participant records, home reviews with participants, continuous quality management and planning, and timely and effective responses to critical incidents.

### **10.1 ADMINISTRATIVE QUALITY ASSURANCE REVIEWS**

MDHHS conducts periodic on-site Administrative Quality Assurance Reviews (AQAR) of each waiver agency on a biennial schedule, assuring MDHHS reviews each waiver agency at least once every two years. MDHHS seeks evidence of compliance to the AQAR standards during the on-site review through examination of waiver agency policies and procedures, provider contracts, financial systems, encounter accuracy, and quality management plans.

Each waiver agency shall adhere to the MDHHS MI Choice Waiver Program Provider Monitoring Plan (known as the Monitoring Plan). The document defines the procedures and standards used by the waiver agency in reviewing providers included in the waiver agency's provider network. It includes the required protocols used to identify provider deficiencies and identifies timelines for remediation. (Refer to the Directory Appendix for additional information.) MDHHS will review each waiver agency's process in detail during the AQAR.

MDHHS notifies each waiver agency in writing of deficiencies requiring corrective action and provides a date for the waiver agency to provide a corrective action plan to MDHHS. In the event of a continued deficiency, MDHHS has the authority to take action toward the waiver agency, including suspending new enrollments, adjusting capitation payments, or mandating further corrective action. MDHHS has the option to suspend or terminate the contract of any waiver agency that fails to correct stated deficiencies identified on a second review.

### **10.2 QUALITY MANAGEMENT PLANS**

Each waiver agency shall have a written quality management plan that meets requirements specified in the MDHHS Quality Management Plan. The Quality Management Plan addresses quality assurance and improvement using measurable goals and quality performance indicators.

MDHHS reviews quality management plans annually. Waiver agencies are required to submit an annual report to MDHHS highlighting its quality management plan activities and improvements. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

### **10.3 CLINICAL QUALITY ASSURANCE REVIEWS**

MDHHS conducts an annual Clinical Quality Assurance Review (CQAR) of each waiver agency. The review is to determine whether the authorized services in the plan of service are sufficient to protect the health and welfare of the participant.

Randomly selected records are reviewed. Samples are derived using federally-approved sampling techniques with a minimum of 10 records reviewed at each agency. In addition, a minimum of five home



visits are conducted to verify information in the records. The review is conducted by a team of trained MDHHS reviewers.

## **10.4 CRITICAL INCIDENT RESPONSE AND REPORTING**

MI Choice is required to track and to report certain events that might indicate exceptional risk to the participant. Not only are these requirements defined in regulation, but in law as well.

### **10.4.A. TYPES OF CRITICAL INCIDENTS AND SERIOUS EVENTS**

The following are specific critical incidents or events that must be reported to MDHHS:

- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Neglect
- Physical abuse
- Provider no-shows, particularly when the participant is bed-bound all day or there is a critical need for the service to be provided
- Sexual abuse
- Theft
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Suspicious or Unexpected Death that is related to providing services, supports, or care
- Medication errors
- Restraints, seclusion or restrictive interventions

### **10.4.B. CRITICAL INCIDENT RESPONSE**

MI Choice waiver agencies have the initial responsibility for identifying, investigating, evaluating and responding to critical incidents that occur with participants as listed above. All suspected incidents of abuse, neglect and exploitation require reporting to MDHHS Adult Protective Services (APS) for investigation and follow-up. Agencies shall begin investigating and evaluating critical incidents within two business days of the date that it was noted that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.

Each waiver agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect or exploitation. The policies and procedures must include procedures for follow-up activities with MDHHS-APS to determine the result of the reported incident and the steps to be taken if the results are unsatisfactory. All reports to MDHHS-APS must be maintained in the participant's case record.



## 10.4.C. CRITICAL INCIDENT REPORTING

Waiver agencies are responsible under contract for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. Waiver agencies are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of knowledge of the incident. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies. MDHHS must receive notification from waiver agencies of suspicious deaths within two business days.



## **SECTION 11 – APPEALS**

MDHHS has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E of the Code of Federal Regulations. Provider appeal rights conform to the requirements of the Michigan Compiled Laws, MCL 400.1 et seq., and the administrative rules found at Michigan Administrative Code R 400.3402 through R 400.3425, amended.

### **11.1 PARTICIPANT APPEALS**

MDHHS has established notice and appeals requirements to which waiver agencies must adhere when adverse action has been taken for program applicants or participants. According to 42 CFR 431.201 "Action" means a termination, suspension, or reduction of Medicaid eligibility or of covered services. This also includes determinations by the waiver agency that the applicant or participant does not meet the nursing facility level of care criteria and other denials of Medicaid eligibility or of covered services.

#### **11.1.A. ADEQUATE ACTION NOTICES**

MI Choice waiver agencies must send an Adequate Action Notice to applicants or participants informing them of adverse actions and determinations taken under the following circumstances:

- when the waiver agency is at operating capacity and unable to enroll MI Choice applicants who request a Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- when the waiver agency determines applicants to be functionally ineligible for MI Choice services based on the results of a LOCD.
- when a participant requests additional services or additional amounts of services and the waiver agency denies the request
- when an existing benefit is reduced, suspended or terminated, and meets the requirements for an exception from an Advance Action Notice as specified in 42 CFR 431.213.

#### **11.1.B. ADVANCE ACTION NOTICES**

An Advance Action Notice must be sent to MI Choice participants when action is being taken to reduce, suspend, or terminate service(s) a participant currently receives. This notice must be provided at least 12 days in advance of the intended action.

An Advance Action Notice is also issued if it is determined that a reduction in level or number of services is warranted based on the participant's current assessment. The notice must inform the participant that services will not be reduced until a formal decision has been rendered through the Medicaid Fair Hearings process if the participant formally requests a hearing before the specified date of the intended action.



## 11.1.C. NOTICES

Advance Action Notices and Adequate Action Notices that relate to the LOCD process are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Waiver agencies may use additional notices for actions not related to the LOCD process. These notices must be approved by MDHHS prior to use to assure compliance with 42 CFR 431.210. Waiver agencies must supply a copy of the Request for Hearing form (DCH-0092) and a return envelope with each notice sent to an applicant or participant, or any time an applicant or participant requests such material. Waiver agencies are required to assist applicants or participants who request help in filing an LOCD exception review through the Michigan Peer Review Organization (MPRO), or a formal appeal for any reason through the Medicaid fair hearings process.

## 11.2 PROVIDER AND WAIVER AGENCY APPEALS

Medicaid providers, including waiver agencies, are afforded appeal rights under the Michigan Social Welfare Act (Public Act 280 of 1939, as amended) and the Michigan Administrative Code. Adverse actions that may be appealed by providers include, but are not limited to, the suspension or termination of participation in the Medicaid program, or a reduction, suspension, or adjustment of provider payments.

A Retrospective Review of the Michigan Medicaid Nursing Facility Level of Care Determination that results in a denial is an Adverse Action for the MI Choice Waiver agency when MDHHS proposes to recover payments made for services rendered to the beneficiary for whom the Retrospective Review was conducted. If the waiver agency disagrees with the MDHHS Adverse Action Notice, the agency may appeal if their written request is received by the MDHHS Michigan Administrative Hearing System within 30 calendar days from the date of the MDHHS Adverse Action Notice.

Information regarding the MDHHS appeal process is available in the General Information for Providers Chapter and on the MDHHS website. (Refer to the Directory Appendix for website information.)