MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONTRACT REQUIREMENTS FOR

SUPPORTS COORDINATION PERFORMANCE STANDARDS

AND

MI CHOICE OPERATING CRITERIA

MI CHOICE PROGRAM

HOME AND COMMUNITY BASED SERVICES WAIVER FOR ELDERLY AND YOUNGER ADULTS WITH DISABILITIES

October 1, 2018

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This document specifies contract requirements for supports coordination activity in the MI Choice Waiver Program. Use this document in tandem with the *Michigan Department of Health and Human Services (MDHHS) Minimum Operating Standards for MI Choice Waiver Program Services.*

I. GENERAL INFORMATION

A. WAIVER PROGRAM BACKGROUND

In March 1992, the Michigan Medical Services Administration (MSA) received approval from the U.S. Department of Health and Human Services (HHS), Centers for Medicare/Medicaid Services (CMS), to implement a *Home and Community Based Services for Elderly and Younger Adults with Disabilities* (HCBS/ED) Medicaid Waiver Program. MDHHS refers to this program as "MI Choice". The MI Choice program expands both the resource limit for Medicaid financial eligibility and limits on the type and volume of services for qualifying adults aged 65 years or older and individuals with disabilities aged between 18 and 64 years who meet the nursing facility level of care (NFLOC) criteria. Michigan citizens who meet specified eligibility criteria may choose to receive waiver services from MI Choice. The purpose of MI Choice is to build and strengthen home and community based service capacity to support fully the long-term care setting preferences for its participants.

In the summer of 1997, the State of Michigan implemented significant changes for MI Choice and the Michigan Aging and Adult Services Agency (AASA) funded Care Management programs. Michigan upgraded its standardized assessment system, adopting the Resident Assessment Instrument- Home Care© (RAI-HC) assessment system to use in the statewide expansion of MI Choice. MDHHS desired the change to utilize highly reliable and scientifically proven assessment and care planning instruments and to produce clinical data within the RAI-HC framework. The assessment instrument used with the RAI-HC system is the Minimum Data Set for Home Care (MDS-HC). The MDS-HC is compatible with the RAI Minimum Data Set (MDS) mandated by the United

States Congress for use in nursing facilities and thus permits comparisons between individuals in nursing facilities and home care.

Additionally in 1997, the State improved its long-term care (LTC) screening system. The University of Michigan and the Hebrew Rehabilitation Center for Aged (Boston, MA) jointly contracted a project to develop an empirically based screen drawing on the MDS-HC assessment information. MDHHS and a research team jointly designed a screening system that MI Choice and Care Management Programs used until November 2004.

During 1998-99, Michigan deployed the MI Choice Information System (MICIS), a computerized on-line operating system infrastructure for the RAI-HC assessment system. MICIS allowed both waiver agencies and state level managers to monitor participant activity and daily program expenditures. Waiver agencies use MICIS to forecast and manage expenditures and to monitor program activity for quality improvement opportunities. However, in 2002 the State re-engineered the MICIS application suite from the public domain in response to a decision to discontinue its information technology service. All waiver agencies were transitioned from a state sponsored server organization to a private MICIS service bureau server. Currently an exporter extracts participant assessment and status information on behalf of waiver agencies and the service bureau submits aggregation updates to the Medicaid data warehouse.

During 2000 and 2001, Michigan waiver staff participated in a three-nation effort with InterRAI involving researchers, clinicians, and policy makers from Canada, the United States, and Japan to develop quality indicators from the MDS-HC data set. Focus groups were held to generate candidate measures that were considered as possible quality indicators from the MDS-HC. Health professionals from six Canadian provinces and MI Choice met to provide input for the research effort at its various stages. This research resulted in 22 MDS-HC Quality Indicators (QIs) that were used in MI Choice as new tools laying the groundwork for a home care quality improvement system. These indicators

provided high-quality evidence on performance at the agency and State level in MI Choice.

In 2004 and 2005, MDHHS implemented a new NFLOC determination instrument used in both institutional and community based settings. In addition, long term-care reform efforts produced a change in process for supporting the needs and preferences of MI Choice participants. MI Choice historically used a team based supports coordination approach as the foundation for assessing, planning, and services management. Adopting self-determination as a principle, MDHHS applied *Person Centered Planning* (PCP) processes to MI Choice, resulting in choice and control by participants. In this service delivery option, the participants retain control over determining, planning, and addressing their own service and support needs and desires.

In November 2004, MDHHS received CMS approval to add community transition services to the array of services available through MI Choice. This sparked the implementation of the Nursing Facility Transition program on January 1, 2005. This program grew exponentially each year until 2011 where it reached a plateau. In fiscal year 2005, MDHHS transitioned about 35 persons from the nursing facility to home and community-based settings. In fiscal year 2015, the total number of participants transitioned was over 1,600.

Michigan enhanced its quality strategy (a quality management plan) with meaningful contributions from participants and their peers who participated in monthly meetings with MDHHS and provider staff from March 2004 to September 2005. A leadership group composed of seven participants, their peers, and seven providers organized formally into the MI Choice Person Focused Quality Management Collaboration (QMC) to work on developing a person focused quality management plan. MDHHS and the Michigan Disability Rights Coalition (MDRC) planned and co-facilitated QMC meetings.

The purpose of the QMC is to include participants and their peers in the development, discussion, and review of quality management activities for MI Choice. The QMC provides a venue where providers, participants, and their peers review and discuss measured provider performance and participant outcomes and recommend improvements to the Michigan Medicaid service delivery system. The QMC also provides participants and their peers with an opportunity to offer meaningful input during the implementation and planning of PCP and self-determination options for MI Choice. In mid-2006, the Collaboration merged meetings with the Self Determination in Long Term Care (SD in LTC) Steering Committee that drives the development and implementation of PCP and SD in LTC. Michigan is one of eleven states selected to receive second round "Cash and Counseling" grants jointly funded by the Robert Woods Johnson Foundation, HHS, Administration on Aging, and Assistant Secretary of Planning & Evaluation. SD in LTC options started at four pioneer sites.

During fiscal year 2008, MDHHS officially implemented PCP and the SD in LTC option expanded statewide. Also during this fiscal year, MDHHS began efforts to upgrade assessment tools from the MDS-HC assessment to the InterRAI Home Care© (iHC) assessment tool. This newest version incorporates ten years of research, development, and testing conducted worldwide by InterRAI. The iHC design is user-friendly, reliable, and person-centered. As with the MDS-HC, the iHC incorporates tools to assist with planning care for each program participant. These tools include 25 Clinical Assessment Protocols (CAPs), case-mix, outcome measurements, QIs, and screening algorithms. MDHHS replaced the MDS-HC with the iHC as the official MI Choice assessment instrument in October 2008.

During fiscal year 2008, MDHHS also received approval from CMS to implement the Money Follows the Person (MFP) program. This program provides enhanced federal matching funds to Michigan for MI Choice participants who transitioned from the nursing facility and meet MFP requirements. The enhanced match is available for the first 365 days of the participant's enrollment in the MI Choice program. Originally, CMS authorized

the MFP grant for five years. However, because of the success of the program, CMS has extended the program through the year 2020. In fiscal year 2016, Michigan determined it would not have enough funds to sustain the MFP program through 2020. MFP enrollments will end sometime in fiscal year 2017 and Michigan's MFP program will officially end during fiscal year 2019.

Fiscal year 2009 brought an expansion of MI Choice into licensed residential settings, e.g. Adult Foster Care (AFC) homes and Homes for the Aged (HFA). MDHHS added Residential Services to the array of available MI Choice services. Residential services enhance the continuum of care for persons in need of long-term care who choose not to receive services in a nursing facility. This option provides services beyond the usual and customary services provided by AFCs and HFAs and allows participants to age in place.

Also in 2009, the Center for Information Management (CIM) deployed COMPASS a new web-based information system for collecting participant data that serves as the successor to MICIS. COMPASS allows HIPAA compliant data transactions and storage and provides comprehensive management software, advanced clinical management tools, and reporting capabilities. CIM serves as the service bureau for most waiver agencies.

In FY 2011, MDHHS collaborated with CIM to develop a web-based portal for the submission and approval of nursing facility transition forms. This portal uses the COMPASS platform and was deployed successfully in June 2011. The portal eliminated the need for paper forms and provides MDHHS, waiver agencies, and Centers for Independent Living with real-time access to information regarding nursing facility transition participants. The portal significantly decreased staff time required to approve and process the many nursing facility transition forms and authorizations required.

In FY 2012, MDHHS collaborated with CIM to develop a web-based portal for the submission of waiting list data. This portal uses the COMPASS platform and was deployed successfully in April 2012. The portal eliminated the need for waiver agencies

to keep and submit spreadsheets containing waiting list information to MDHHS on a quarterly basis. As with other COMPASS applications, the waiting list portal provides MDHHS and waiver agencies with real-time access to information regarding persons waiting for MI Choice enrollment.

FY 2014 brought about significant changes to the MI Choice program. With the waiver renewal, MDHHS chose to convert the payment methodology from fee for service to a capitated, managed care system. MI Choice waiver agencies are no longer Organized Health Care Delivery Systems (OHCDS), but now meet the requirements to be Prepaid Ambulatory Health Plans (PAHPs). To accomplish this, MDHHS submitted to CMS and CMS approved a 1915 (b) waiver administered concurrently with the 1915 (c) waiver. MDHHS also eliminated three services, personal care, homemaking, and residential services. The service Community Living Supports combines common tasks performed in the delivery of these three services and is used as a wraparound service to offer more flexibility to participants in determining exactly how services are furnished to them in their homes. MDHHS also converted Supports Coordination from an administrative activity to a MI Choice service, and added Nursing Services to reflect participant needs for less frequent nursing visits better.

CMS issued several regulations during fiscal years 2014 through 2016 that affect how MI Choice services are delivered. The first was the Home and Community-Based Settings regulations. This regulation affects provider-owned service settings such as AFCs, HFAs, and other assisted living residences. It also includes non-residential providers such as Adult Day Care centers. Waiver agencies must assure that all contracted providers are compliant with this regulation by March 17, 2022. Another significant change with this regulation was that CMS officially required person-centered planning as a part of home and community-based services. CMS issued new managed care regulations in 2016 that become fully effective in 2019.

In FY 2016, several small changes were made to the MI Choice program. MDHHS developed a risk pool to improve payments to waiver agencies who serve higher-cost participants. Additionally, MDHHS submitted an amendment to CMS to add non-emergency medical transportation (NEMT) to the services array. This allows waiver agencies to authorize NEMT for MI Choice participants. This change became effective October 1, 2016.

B. REGULATIONS GOVERNING WAIVER PROGRAM ADMINISTRATION

The MI Choice waiver plan constitutes the State's request and CMS approval for the provision of the home and community based services under Sections 1915 (b) and 1915 (c) of the Social Security Act. The CMS-approved MI Choice waiver plan is an amendment to specific sections in the State's overall Medicaid State Plan for its target population. MSA, the single state Medicaid agency, is responsible for the administration of the MI Choice program and ensuring that MDHHS and its contracted waiver agencies abide by the terms and conditions of the approved waiver. Each waiver agency is a designated PAHP.

MDHHS contracts with PAHPs to administer the MI Choice program in specific areas of the state. MDHHS has approved each PAHP as operating in compliance with the requirements of a PAHP, as defined in 42 CFR 438. The contract requirements in this document detail these activities.

PAHPs, hereafter called waiver agencies, assure each MI Choice participant receives supports coordination (SC) services. Qualified supports coordinators (SCs) work with participants to gain access to and coordinate the services, supports, treatments, and other interventions that participants want and need. SCs utilize PCP processes to authorize and monitor MI Choice services. The policies in this document detail MDHHS SC Performance Standards.

Waiver agencies use the MICIS, COMPASS, or other compatible computerized systems to manage all required data for MI Choice. Waiver agencies submit program data to the MDHHS Data Warehouse as specified in the contract.

Waiver agencies utilize The Person Centered Planning for Community Based Long Term Care: Practice Guidance for MI Choice Waiver Sites to implement PCP in this home and community based setting.

Federal regulatory source documents include the Social Security Act, Code of Federal Regulations (CFR), CMS Audit Guidelines and Decisions; CMS instructions, technical guides, and review criteria, and Medicaid Policy.

C. ELIGIBLE POPULATION

Adults (persons 18 years of age or older) who meet the Michigan Medicaid NFLOC criteria, the expanded Medicaid financial eligibility criteria specified in the waiver plan, and require at least one MI Choice service in addition to supports coordination comprise the population eligible for MI Choice. The MI Choice population specifically <u>excludes</u> following groups:

1. Medicaid eligible persons who reside in intermediate care facilities for the individuals with intellectual disabilities (ICF/IID), or a state psychiatric hospital,
2. Medicaid eligible persons enrolled in a qualified health plan (e.g., health maintenance organization) or managed care organization,
3. Persons enrolled in Program of All-Inclusive Care for the Elderly (PACE),
4. Persons enrolled in the Habilitation Supports Waiver program,
5. Persons enrolled in the MI Health Link program,
6. Persons enrolled in the Home Help Services program whose service and support needs are fully met by that program,
7. Persons enrolled in the Healthy Michigan Plan who do not have a disability determination,
8. Nursing facility residents, and

9. Medicaid eligible persons admitted to a hospice facility.

II. MI CHOICE VISION & VALUES

Michigan's Long-Term Services and Supports (LTSS) policies and resulting operating principles should support citizens to maintain their ability to exert control over their lives, including supporting citizen preferences to remain in their home, neighborhood, and community. This LTSS Vision and Values Statement is intended to present a science-based, consensus vision of what can and should be achieved for Michigan's citizens in need of services. The Statement's fundamental purpose is to help guide the day-to-day and year-to-year decisions and actions of Michigan public and private organizations concerned about LTSS. This will help to ensure current actions and solutions effectively contribute to Michigan's progress toward an optimal LTSS system.

Over the next decade, Michigan organizations concerned about LTSS will support the development and implementation of an optimal LTSS services system that will:

A. Respect, support, encourage, and promote individual self-determination and family/community empowerment and involvement. Michigan will demonstrate this through the availability of culturally competent services, PCP, individual choice of care settings, and maximizing individual control over service provision and resource utilization.

B. Create an efficient and dynamic continuum of LTSS including in-home services, assisted living of various kinds, SC services, respite care services, nursing facility care, hospice care, primary care, chronic SC, and acute hospital care services.

C. Provide accessible, regionally and locally decided single points of information, assessment, care planning, and entry into the system for those seeking LTSS ensuring that each individual is supported to make fully informed decisions about his or her services with the participation of chosen family and friends.

D. Use person-centered processes and tools to assess and match the individual's needs and desires across a continuum of LTSS based on demonstrated need, effective individualized management, and services and supports planning.

E. Support Michigan's home and community based service system by assuring that all those who need high levels of services and supports have a range of options that allow them to live in the community, if that is their choice. Sufficient support and services can be applied in cost efficient ways through an accessible home and community-based service system.

F. Build and sustain an adequate, well-trained, highly motivated, and appropriately compensated workforce across the LTSS continuum.

G. Include the planning and oversight of efforts to realize this vision, including a central, meaningful role for participants and families, as well as other stakeholders.

H. Build the capacity to educate the general population by increasing awareness about the continuum of LTSS, insurance options, and making informed choices.

III. PERSON CENTERED PLANNING

PCP is a process for planning and supporting the participant that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices and abilities. PCP includes the participant and aims to elicit the participant's preferences, dreams, desires, and goals for their life. SCs use PCP processes in every aspect of coordinating services and supports for participants. PCP frames the service and supports planning process in participant's terms. It generates discussion about the participant's strengths, gifts, and capabilities in addition to their needs, so that it builds upon the individual's abilities instead of focusing solely on the individual's limitations.

This is a highly individualized option designed to respond to the expressed, as well as assessed, needs based on desires and preferences of the participant. The PCP process requires the involvement of family, friends, professionals, caregiver staff, and other allies, as selected by the participant, to contribute in planning activities.

The principles inherent in PCP constitute an overarching option for the coordination and delivery of MI Choice services. While participants may choose not to participate in the PCP process, SCs must offer each participant this option. The participant and SCs initiate the PCP process at a mutually agreed upon time. Typically, PCP should not be conducted when the participant is in a crisis. MI Choice also supports the Independent Living philosophy that

acknowledges that those who best know what services and supports persons with disabilities need are the persons with disabilities.

Requirements

The participant directs the person-centered planning process. The process:

1. Includes people chosen by the individual.
2. Provides necessary information and support to ensure the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
3. Is timely and occurs at times and locations of convenience to the participant.
4. Reflects cultural considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
6. Offers choices to the participant regarding the services and supports the participant receives and from whom.
7. Includes a method for the participant to request updates to the plan, as needed.
8. Records the alternative home and community-based settings that were considered by the participant.

IV. SUPPORTS COORDINATION

SC is the method that facilitates access to and arrangement of services and other forms of support needed and wanted by MI Choice participants. SCs work with participants to determine how and who will meet the participant's LTSS needs. SCs assist participants in arranging for services and supports and monitor the quality of services received. SC includes valuing the cultural backgrounds of participants in the decision making process.

A. DEFINITION

SC is a service designed to inform, assist, and coordinate a variety of home and other community-based services needed by elderly and other adults with disabilities aged 18

years and older who meet the NFLOC. SCs utilize all available services and supports before authorizing MI Choice services while assisting the participant in planning interventions. SCs work in partnership with participants to determine the interventions that will promote the participant's goals and facilitate the achievement of desired outcomes while addressing the participant's service and support needs.

SCs build participant choices and preferences into the SC process to assure a person-focused, self-determination approach to the receipt of services and supports. SCs arrange formal services based upon participant choice and approval. The participant and their SCs explore other funding options and intervention opportunities when personal goals expand beyond meeting basic needs.

B. SUPPORTS COORDINATION SERVICE FUNCTIONS

SCs provide all of the following functions:

1. Assessment

The iHC Assessment System, consisting of the iHC and CAPs, is the basis for the MI Choice Assessment. SCs perform a comprehensive evaluation including assessment of the individual's: unique preferences; physical, social, and emotional functioning; medication; physical environment; natural supports; and financial status. The SC must fully engage the participant in the interview to the extent of the participant's abilities and tolerance.

Specific iHC items identify applicants who could benefit from further evaluation of particular problems and risks for functional decline. These items, called "triggers," link the iHC to a series of problem oriented CAPs. The CAPs are procedures that guide the SCs through further assessment and individualized service and support planning with participants.

2. **Person Centered Service Plan Development**

   SCs and participants plan interventions from both allies and community resources that will meet each participant's identified needs. A written person-centered service plan (PCSP) documents the issues, concerns, conditions, and specific supports and interventions needed. The SC and participant base the PCSP upon participant preferences and needs identified during a PCP assessment process. The PCSP must be completed and approved by the participant within 90 days.

3. **Service Access**

   SCs and participants arrange and/or purchase in-home health and social services and supports established in the approved PCSP. SCs provide education of participant options in receiving services and supports.

4. **Follow-Up and Monitoring**

   SCs contact participants to ensure that responsible parties implement plans of service as written and according to participant preferences.

5. **Reassessment**

   On a periodic basis, SCs conduct a standardized in-person reexamination of the participant's needs, strengths, and preferences, using the iHC.

6. **Social Emotional Support**

   SCs provide support to participants and their allies to facilitate life adjustments and reinforce the participant's circle of support. SCs also conduct case conferencing as determined necessary and approved by the participant.

7. **Advocacy**

   SCs provide support to ensure participants and their families receive benefits and services they need and to which they are entitled. SCs also provide assistance with accessing Medicare, Medicaid, and other third party benefits and services.

C. STANDARDS OF SUPPORTS COORDINATION

Waiver agencies provide SC activities consistent with the principles listed below:

1. SCs follow the principles of PCP; including providing opportunities for participants to express goals, desires, and expectations and supporting the involvement of allies to participate in planning activities.
2. Qualified SCs perform the initial MI Choice assessment function as a team. Qualified staff includes a Registered Nurse (RN) and a Social Worker (SW), both with valid Michigan licenses to practice their profession.
3. SCs receive ongoing training and supervision, as appropriate.
4. SCs identify and discuss all potential supports and service options and emphasize participant choices and preferences.
5. The SCs assure the participant's rights. This includes the right to participate actively in SC services including the development of the PCSP, the right to use a supports broker, the right to receive or refuse services, the right to choose providers, and the right to participate in a PCP process.
   - **a)** Every MI Choice participant signs a Freedom of Choice consent form to receive services from MI Choice. CHAMPS will generate this form for each participant once the completed NFLOC Determination is entered online. Waiver agencies follow the requirements defined in the MI Choice chapter of the Medicaid Provider Manual available online at:
     http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
   - **b)** Participants must be informed of the following:
     - **(1)** Services available in MI Choice, PACE, MI Health Link, and nursing facilities. Participants or their legal representative must sign the freedom of choice form to indicate their preference for MI Choice. Waiver agencies maintain properly completed, signed, and dated forms in the participant's case record.
     - **(2)** The consent to receive MI Choice services remains in effect as long as the participant's case is open or until revoked by the participant or by a relative or

other legally responsible adult only when the participant is determined legally incompetent or is physically unable.

(3) Services available through the Medicaid State Plan which may meet their needs. Examples include the Home Help Services program available through the MDHHS Field Office. Persons who qualify for the Home Help program and for whom this program will fully meet their services and support needs do not qualify for the MI Choice program because they do not have the need for a waiver service.

6. Waiver agencies shall have policy and procedures acknowledging the participant's authority to make decisions about the planning process and evaluate the PCSP and its outcomes.

7. Waiver agencies have a written local quality management plan for its SC operations that include supervisory oversight procedures, clinical review of SC functions, methods used to identify programmatic deficiencies, and methods used to provide feedback to effect improvements. These plans must also include CMS and MDHHS requirements as specified in 42 CFR 438.608 and Attachment C of the MI Choice contract. MDHHS annually reviews the internal SC quality management plan, QM plan outcomes, and accomplishments as cited in annual reports.

8. Waiver agencies have written complaint procedures to monitor, investigate, and follow up on concerns expressed by participants. The primary objective of the complaint procedure is for the waiver agency to resolve concerns to the satisfaction of the participant. Each waiver agency maintains a complaint file separate from complaint content logged into individual case records.

9. MDHHS Clinical Quality Assurance Reviews (CQAR) of MI Choice services determines the level of compliance with clinical and programmatic standards and evidence of the protection of the health and welfare of participants. The primary means of gathering information for the CQAR include reviewing case records and interviewing waiver agencies and participants.

10. Waiver agency staff respects each participant's cultural background.

D. LEGAL LIMITATIONS AND DISCLOSURE OF INFORMATION

Legal limitations exist on disclosing confidential information about the participant. CMS published the Standards for Privacy of Individually Identifiable Health Information, in the Code of Federal Regulations (CFR) at 45 CFR Parts 160 and 164 ("Privacy Rule") following the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which was enacted to protect the privacy of information related to an individual's health, treatment, or healthcare payment. It limits the use by a covered entity (e.g. waiver agencies) of protected health information (PHI), sent or stored in any format (electronic, paper, voice, etc.) without participant authorization, ensures that business associates (e.g. service providers) who receive PHI from a covered entity must ensure the privacy of the records and also grants participants the right to access their own medical records, and request changes if they feel the information is not accurate.

Waiver agencies and contracted service provider agencies have procedures in place to protect confidential PHI in accordance with federal standards. Waiver agencies and contracted service providers maintain all participant information (written or electronic) in controlled access files.

Requirements

1. The participant shall authorize the use or disclosure of PHI under the HIPAA by signing a Release of Information and Consent Form (ROI). The ROI shall include the following information:
   - **a)** Permission to use or disclose PHI for purposes beyond treatment, payment, or health care operations.
   - **b)** A description of the PHI to be disclosed
   - **c)** The purpose for the disclosure
   - **d)** The intended recipient(s)
   - **e)** The participant's right to withdraw consent of release at any time

f) The date the authorization expires, not to exceed one year from the date of participant signature.

g) Participant or legal representative signature and date. A relative or other representative may only sign the release when the participant is determined legally incompetent or is physically unable. The case record must clearly document why participants cannot sign the ROI themselves.

h) The signature and date of SC completing the form.

2. Disclosure of information to others does not abrogate, by itself, a participant's expectation of privacy as protected by the law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure.

3. The SC may only make disclosures of information for purposes directly related to the administration of the program for which the participant is applying or from which the participant is receiving benefits.

4. Disclosure of pertinent participant information from the SC to a service provider does not authorize that service provider access to the participant's complete record. Disclosure beyond what the SC initially volunteers is at the discretion of the participant and SC.

5. Waiver agencies, SCs, service providers, and others related to a participant's services and supports are not to identify the participant by name in publicly distributed reports.

V. INTAKE

The waiver agency engages participants for involvement throughout the intake process to:

1. Assist in the completion of the NFLOC determination process and to solicit their expectations for assistance and support from the waiver agency;
2. Identify needs for any communication accommodations;
3. Identify relevant individuals (or allies) invited by the participant to the assessment meeting; and
4. Determine issues that participants prefer not be addressed in the assessment meeting.

A. REFERRAL SYSTEM

The waiver agency shall develop procedures to manage referral requests for MI Choice services.

Requirements

1. The waiver agency provides orientation/referral training to referral sources to describe characteristics of the target population, NFLOC criteria, financial eligibility, and a MI Choice program description to facilitate appropriate referrals.
2. The waiver agency provides additional information and follow-up as necessary to key agencies, i.e., hospitals, home health agencies, other community organizations, and individuals making MI Choice referrals.
3. Following a request for MI Choice services, the waiver agency evaluates all applicants using the MI Choice Intake Guidelines (MIG) according to the MI Choice Chapter of the Medicaid Provider Manual and all subsequent revisions or amendments made thereto. The purpose of the MIG is to determine the applicant's likelihood of meeting program eligibility criteria and their willingness to participate in MI Choice when the waiver agency has enrollment capacity.
4. Waiver agencies establish written procedures that meet MDHHS requirements for managing referrals during periods when demand for MI Choice services exceeds program capacity. During such periods, waiver agencies must manage a prioritized waiting list according to the MI Choice Chapter of the Medicaid Provider Manual and all subsequent revisions or amendments made thereto.
5. Waiver agencies inform individuals who request placement on the wait list about the availability of the Home Help Services program and provide information about how they can apply for this program through the MDHHS Field Office. Waiver agencies also notify individuals of PACE and MI Health Link programs and other waiver agencies available in the area and how to access them.

6. Waiver agencies periodically contact individuals on their wait list to determine their status. Waiver agencies remind individuals on the wait list of the availability of the Home Help Services, PACE, and MI Health Link programs and other waiver agencies and how to access these programs. Waiver agencies also assess individuals to determine if they are at imminent risk of nursing facility placement, and move such persons to the appropriate category on the wait list.
7. Waiver agencies must provide assistance to accommodate persons with Limited English Proficiencies (LEP) with accessing MI Choice services. Oral and written assistance to persons with LEP may take various forms, including hiring bilingual staff, arranging for interpreters, and translating written materials when a significant number or percentage of program beneficiaries require information in a language other than English.

B. LEVEL OF CARE DETERMINATION

Waiver agencies use the Michigan Medicaid NFLOC Determination guidelines and instruments to evaluate each applicant's medical eligibility for the MI Choice program as described in the MI Choice Chapter of the Medicaid Provider Manual. Waiver agencies utilize the MIG to determine the appropriateness of a face-to-face encounter to apply the NFLOC criteria.

Requirements

1. Waiver agencies conduct the MIG according to established Medicaid policy, guidelines, and instructions. For individuals who appear eligible from the application of the MIG and request enrollment in MI Choice, waiver agencies apply the NFLOC criteria at a face-to-face meeting with the applicant within seven days of completion of the MIG, or place the applicant on its wait list in the appropriate priority category by date of request.
2. Applicants have the right to refuse services and a NFLOC determination. When an applicant refuses to participate in the NFLOC determination, the waiver agency must inform the individual or authorized representative that he or she will not be eligible for

MI Choice services until the waiver agency conducts the NFLOC and determines medical eligibility.

3. For individuals who appear to meet the NFLOC criteria, waiver agencies shall provide an information packet explaining the MI Choice services, the PCP process, availability of the SD in LTC option, rights, grievance and appeals information, and a list of items needed to complete the assessment. In addition, agencies solicit participant preferences for date, time, and place of the assessment meeting before finalizing schedules.
4. Waiver agencies inform referral sources of the eligibility disposition of persons referred to MI Choice.
5. Waiver agencies send individuals who do not appear to meet the NFLOC criteria a completed adequate action notice and a Request for an Administrative Hearing Form. Waiver agencies attempt to link such applicants to other appropriate community-based services, including the Home Help Services program.
6. Waiver agencies have policy and procedures that identify and immediately address inaccurate or inappropriate NFLOC determinations.
7. Waiver agencies adhere to NFLOC requirements stated in the MI Choice chapter of the Medicaid Provider Manual and all policy revisions or amendments.
8. Upon completion of NFLOC tool, the waiver agency completes the Michigan Medicaid NFLOC determination online for each applicant. The NFLOC determination and on-line submission of the tool must occur within 14 days of conducting the in-person determination. The final determination of NFLOC eligibility is made by MDHHS with the online submission of the NFLOC data. The waiver agency specifies its Medicaid Provider Identification Number and/or National Provider Identification (NPI) number for each NFLOC tool completed, as well as the Medicaid Recipient Identification number for each applicant. If an applicant does not yet have a Medicaid Recipient Identification number, the waiver agency must complete this portion of the tool as soon as the MDHHS Field Office notifies the waiver agency of this number. Failure to complete this tool properly may result in the waiver agency not receiving the MI Choice capitation payment for the participant.

9. Waiver agencies shall formally reevaluate a participant's NFLOC at least annually. However, documentation within the case record shall affirm the participant meets NFLOC criteria on a continual basis. Waiver agencies may manage NFLOC affirmations through the reassessment process. MDHHS **requires** completion of an additional online NFLOC Determination prior to the expiration of the current NFLOC tool.
10. Online completion of the NFLOC Determination form **is required** upon the determination that the participant no longer meets the NFLOC criteria.
11. Online completion of the NFLOC Determination form **is required** for each MI Choice enrollment period or according to MDHHS NFLOC Determination policy.

VI. ASSESSMENT ACTIVITIES

A. GENERAL INFORMATION

The waiver agency has qualified SC teams comprised of an RN and a SW conduct an assessment with each applicant determined eligible by the NFLOC criteria, in accordance with the policies contained in this document. Both members of the team complete the initial MI Choice assessment. Waiver agencies need to complete an initial MI Choice assessment using a SC team for participants currently enrolled in the AASA Care Management program who are transferring to the MI Choice program before starting MI Choice services for the participant.

The assessment is conducted primarily to:

1. Identify comprehensive information regarding the participant's strengths, needs, preferences, current supports, health, and functional status;
2. Confirm the applicant's need for supports coordination and at least one additional MI Choice service on a regular basis;
3. Assist in planning for the applicant's needed services, supports and interventions;
4. Inform the assessed applicant of MI Choice program options; and
5. Obtain the applicant's formal consent for participation in MI Choice.

Requirements

Waiver agencies solicit and honor participant preferences concerning the time and location of the assessment as well as who is to attend the assessment meeting. SCs are trained to conduct assessments according to written protocols contained in the InterRAI-HC Assessment Manual.

1. SCs complete all mandatory items on the written or electronic assessment form or document the reason for an incomplete item on the form.
2. RNs complete the medical sections of the assessment while SWs complete the social sections of the assessment.
3. SCs inform the applicant of feasible alternatives to receive LTSS and secure in writing the applicant's stated freedom of choice for the preferred setting for supports and services.
4. SCs secure the applicant's informed consent to participate in the MI Choice program by obtaining and completing a ROI form.
5. SCs inform the applicant of rights and responsibilities to receive Medicaid services, and to appeal actions and decisions when needed during unresolved disagreement.
6. When the SCs assess applicants in nursing facilities, hospitals or outside of their usual living environment, the SCs must also see the applicant in their home environment to update assessment information and to assess the home environment. This update should occur within one week after the return to the home environment.
7. MDHHS requires electronic data collection for all assessments completed for MI Choice applicants. SCs must input all assessment data into an electronic system, such as COMPASS. The data system must record the date of and person responsible for any additional information put in the record or changes made to the original assessment data collected.

B. MEDICAL/FUNCTIONAL ELIGIBILITY

MDHHS retains responsibility for the final decision regarding medical/functional eligibility for MI Choice. MDHHS reviews waiver agency NFLOC determinations during the CQARs by comparing the completed NFLOC determination with the corresponding iHC assessment data. Waiver agencies assist and link persons determined medically eligible

from the NFLOC determination to the MDHHS Field Office for a financial eligibility determination.

C. FINANCIAL ELIGIBILITY

Financial eligibility for Medicaid LTSS services is determined by the State through the MDHHS Field Office. The MDHHS Field Office will complete the financial eligibility determination process within the defined standard of promptness and notify the applicant and the waiver agency of the outcome.

Waiver agencies offer assistance to persons determined medically eligible who need to apply for Medicaid assistance. The waiver agency collects financial information during the assessment to substantiate an applicant's potential financial eligibility. Information is assembled for verification review and a Medicaid application is completed for submission to the MDHHS Field Office with all required financial documentation.

All individuals shall meet Medicaid financial eligibility criteria as stated in the MDHHS Bridges Eligibility Manual (BEM) and the CMS-approved MI Choice waiver application.

Requirements

1. The waiver agencies have written procedures to evaluate and verify participant income, assets, and expenses on a regular basis, not less than annually, and to advise participants when excess resources may threaten program eligibility.
2. Waiver agencies cannot request that participants contribute or donate funds to MI Choice to pay for MI Choice services.
3. Waiver agencies offer assistance to persons determined medically eligible for MI Choice who need to apply for Medicaid assistance. If the participant accepts the assistance, the waiver agency collects relevant financial information to substantiate an applicant's potential financial eligibility. Waiver agencies assist the participant with completing the Medicaid Assistance Application and either submit the application

online, or deliver application packets, containing the application and verifications, to the MDHHS Field Office for review and consideration of Medicaid eligibility.

D. ESTABLISHING WAIVER ELIGIBILITY

All applicants must meet three conditions for MI Choice eligibility:

1. Medical/Functional Eligibility

Qualified professionals as specified in the MI Choice Chapter of the Medicaid Provider Manual, and any updates made thereto, determine medical eligibility for each participant based on the NFLOC determination criteria. MDHHS makes the final decision regarding medical/functional eligibility.

2. Financial Eligibility

All applicants must meet Medicaid financial eligibility criteria as defined in the MDHHS Bridges Eligibility Manual (BEM) and the CMS-approved MI Choice waiver application to participate in MI Choice. The MDHHS Field Offices notify waiver agencies in writing as to the eligibility determination, confirming waiver eligibility dates and the participant Medicaid identification number.

3. Service Need

SCs document the need for at least one MI Choice service, in addition to supports coordination, as a condition of participation in MI Choice. SCs determine initial and ongoing MI Choice service needs with participants and their allies using standardized assessment and reassessment tools and PCP practices.

Requirements

1. Waiver agencies establish written procedures to verify financial information reported at assessment and to ensure timely preparation and submission of the Medicaid application.
2. Waiver agencies may not discriminate against an individual and their ability to enroll in the MI Choice program based upon any of the following:

a. Health status or need for health care services
b. Race, color, or national origin and
c. Will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin

3. Waiver agencies may not enroll individuals in MI Choice for the sole purpose of enabling the individual to obtain Medicaid eligibility.

4. Enrollment in MI Choice is voluntary, and each applicant shall be informed of such.

5. Waiver agencies must follow and accept individuals in the order in which they apply, according to the waiting list priority categories as long as the waiver agency has an available slot for an enrollment.

6. Waiver agencies enroll applicants the waiver agency determines eligible for MI Choice services, who consent to participate in MI Choice, and for whom the other community-based services, such as the Home Help Services program will not fully meet the service and support needs of the applicant.

7. Participants require at least one MI Choice service in addition to supports coordination. Each participant must receive at least one MI Choice service in addition to supports coordination monthly. The only exception to this requirement is during periods when the waiver agency cannot secure a provider to furnish services for the participant, such as upon enrollment or upon the loss of a caregiver. During these times, the case record must clearly reflect attempts to secure a service provider for the participant.

8. The waiver agency provides applicants determined ineligible for MI Choice services timely written notice of the applicant's appeal rights and information on how to exercise those rights. The waiver agency may also provide information and referral to community services appropriate to their level of need.

VII. ENROLLMENT

After eligibility is determined, waiver agencies manage applicant enrollment into MI Choice. Waiver agencies develop written procedures for managing enrollment activities that are consistent with MDHHS policy.

A. FIRST DAY OF MI CHOICE ENROLLMENT

The waiver agency establishes MI Choice enrollment and termination dates. The agency is responsible for providing written notification to the MDHHS Field Office of these dates (see BEM 106) and the MDHHS Field Office will confirm eligibility for the dates specified. As of January 2, 2018, the waiver agency must enter enrollment and disenrollment information directly in CHAMPS. CHAMPS will then notify the MDHHS Field Office of the enrollment and disenrollment dates and will update Bridges as necessary. The MI Choice enrollment date is on or following the assessment date. The enrollment date usually coincides with the date of assessment. However, the following situations may delay enrollment for a MI Choice participant:

1. The waiver agency assesses an applicant in a nursing facility, hospital, or the applicant has another Medicaid level of care code or Program Enrollment Type (PET) code assigned at the time of the assessment.
   - **a)** On a date following assessment, the applicant returns home, to the community, or terminates participation in the other level of care setting or Medicaid program. MI Choice enrollment may begin only after the individual returns home or terminates participation in the other program.
   - **b)** Waiver agencies coordinate with the MDHHS Field Office or the other program to ensure termination from the other program before enrolling the participant in MI Choice. As a reminder, individuals transferring from MI Health Link, PACE, or the Habilitation Supports Waiver may only do so on the first of the month. As of January 2, 2018, waiver agencies submit enrollment information in CHAMPS.
   - **c)** The waiver agency establishes the applicant's enrollment date on a date following discharge from the nursing facility, hospital, or other program. MI Choice enrollments can occur on the day of discharge from the nursing facility or hospital.
2. An applicant enters a hospital after the waiver agency conducts an assessment. The waiver agency must delay establishing the enrollment date until after the applicant is discharged from the hospital.

3. The applicant currently participates in the Home Help Services program. The waiver agency verifies and documents that the Home Help Services program no longer meets the service and support needs of the applicant. Waiver agencies may only make this determination through an in-home assessment and evaluation of the applicant. Waiver agencies MAY NOT require the individual to request and have additional Home Help Services benefits denied before making this determination. The applicant meets NFLOC criteria, requires supports coordination and at least one additional MI Choice service not available through the Home Help program, **and** chooses to participate in MI Choice.
   - **a)** The waiver agency requests termination of the Home Help Services program before MI Choice enrollment and asks the applicant to notify the MDHHS Field Office of this decision to terminate the Home Help Services program enrollment.
   - **b)** Participants are entitled to receive Medicaid State Plan services while in MI Choice; however; MI Choice will meet all personal care needs so that the individual does not require Home Help Services when enrolled in MI Choice. The SCs should fully explain this choice to applicants requesting to switch from the Home Help Services program to MI Choice.
4. An applicant is assessed at the end of a month. The waiver agency with approval from the applicant may establish the MI Choice enrollment date on the first day of the following month.
5. The waiver agency assesses the applicant and determines the applicant meets NFLOC criteria, but has excess assets. The waiver agency shall delay enrollment into MI Choice until the MDHHS Field Office determines the applicant financially eligible.
6. The applicant is enrolled in another managed LTSS program, including MI Health Link, PACE and Habilitation Supports Waiver, at the time of assessment. These are managed care programs where disenrollment is effective at the end of the month. The waiver agency will have to coordinate the MI Choice enrollment date to be the first day of the month after the effective date of the MI Health Link, PACE or Habilitation Supports Waiver disenrollment.

7. The applicant does not have Medicaid at the time of assessment. Before the waiver agency can presume the applicant eligible for MI Choice, the applicant must submit a Medicaid application to the MDHHS Field Office. The waiver agency has several choices once the Medicaid application is in the approval process.

a) The waiver agency may wait to determine the MI Choice enrollment date. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility. This means the applicant has been **approved** for the waiver. The waiver agency will not **enroll** the applicant in MI Choice until the MDHHS Field Office confirms Medicaid eligibility. MI Choice enrollment occurs when all eligibility criteria has been confirmed and the waiver agency starts providing MI Choice services. In this situation, the first date of MI Choice enrollment cannot be sooner than the date the MDHHS Field Office confirms Medicaid eligibility, regardless of any retroactive Medicaid eligibility dates. It may be necessary to complete an additional NFLOC determination or iHC assessment depending on the length of time it takes the MDHHS Field Office to make this determination. It will also be necessary to complete another MI Choice enrollment notice with the actual date of enrollment and submit this to the MDHHS Field Office. Effective January 2, 2018, the waiver agency should not enter enrollment information into CHAMPS until Medicaid eligibility is determined and the enrollment date is verified. The waiver agency cannot assign the applicant a status of Waiver/Pending or Waiver/Yes from the date of assessment to the date of Medicaid eligibility confirmation. The applicant may have an eligibility status of Waiver/Ineligible or Waiver Financially Ineligible while waiting for the Medicaid confirmation.

b) The waiver agency may presume the MDHHS Field Office will approve the applicant's Medicaid application. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility, and has determined the applicant "approved" for the waiver. The waiver agency implements the full array of services identified in the applicants' PCSP, and proceeds as if the applicant met all eligibility

criteria. In this situation, the waiver agency may assign a status of Waiver/Pending to the applicant. Once the MDHHS Field Office confirms Medicaid eligibility, the waiver agency may change the Waiver/Pending status to Waiver/Yes as of the date of the initial assessment or the first day of Medicaid eligibility, whichever is later. As of January 2, 2018, the waiver agency may enter the MI Choice enrollment date in CHAMPS. The MI Choice PET will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. If the first day of Medicaid eligibility is later than the initial assessment date, the waiver agency reclassifies the days from the initial assessment date to the first date of Medicaid eligibility to Waiver/Ineligible in the status tables. The waiver agency will need to send another enrollment notice to the MDHHS Field Office to confirm the MI Choice enrollment date. As of January 2, 2018, the waiver agency will need to notify MDHHS Home and Community Based Services Staff to correct the initial MI Choice enrollment date in CHAMPS.

c) The waiver agency may presume the MDHHS Field Office will approve the applicant's Medicaid application. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility and has determined the applicant "approved" for the waiver. The waiver agency implements the full array of services identified in the applicants' PCSP, and proceeds as if the applicant met all eligibility criteria. In this situation, the waiver agency may assign a status of Waiver/Pending to the applicant. As of January 2, 2018, the waiver agency may enter the MI Choice enrollment date in CHAMPS. The MI Choice PET will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. If the MDHHS Field Office denies Medicaid eligibility, the waiver agency may change the Waiver/Pending status to Waiver/Ineligible as of the date of the initial assessment. The waiver agency will need to send a disenrollment notice to the MDHHS Field Office to confirm the applicant never enrolled in MI Choice. As of January 2, 2018, the waiver agency will need to notify MDHHS Home and Community Based Services Staff to correct the initial MI Choice enrollment date in CHAMPS.

B. Program Enrollment Types

As of January 2, 2018, neither Bridges nor CHAMPS will use Level of Care codes. CHAMPS will use PET codes instead. Waiver agencies will submit enrollment information directly to CHAMPS and CHAMPS will assign the appropriate PET code once all information required is verified.

1. Hospice Enrollment

An exception to the single LOC rule is enrollment in both MI Choice and Hospice. A participant in the MI Choice program may receive Hospice services simultaneously. Bridges indicates Hospice enrollment with a LOC code "16." The LOC code in Bridges must be "22" when someone is enrolled in both MI Choice and Hospice. As of January 2, 2018, individuals who are enrolled in both MI Choice and Hospice will have a PET code indicating this. PET codes for MI Choice are available in MDHHS policy bulletin 17-40. For additional information, refer to the Hospice chapter of the Medicaid Provider Manual, section 5.6.D. Participants who receive both MI Choice and Hospice services must have a coordinated PCSP. MDHHS may employ a post-payment review to monitor services. If MDHHS finds that inappropriate (i.e., duplicative) services were authorized, MDHHS seeks recovery of Medicaid funds paid for duplicative services from the waiver agency.

2. Medicaid Qualified Health Plans (QHP)

An applicant enrolled in a Medicaid Qualified Health Plan (QHP) must choose between MI Choice services or the QHP. A Medicaid recipient cannot receive MI Choice services and enroll in the Medicaid QHP. When an applicant chooses MI Choice, the waiver agency faxes a disenrollment request to the MSA Enrollment Services Support Unit at (517) 373-1437. Waiver agencies develop their own form on agency letterhead. As of January 2, 2018, waiver agencies will enter MI Choice enrollment

information directly in CHAMPS. Additional notification to MSA Enrollment Services Support is not necessary.

The correspondence includes the following waiver agency information:

- Name
- Medicaid provider identification number

The correspondence should also include the following participant information:

- Name
- Medicaid identification number
- Medicaid case number
- The requested date of disenrollment from the established LOC (usually one day prior to MI Choice enrollment)
- Requested MI Choice enrollment date (LOC 22 begin date)

3. Nursing Facility Admissions

When a MI Choice participant is admitted to a nursing facility from MI Choice, MDHHS edits the participant's LOC code on Bridges from “22” to “02” (to indicate nursing facility admission) on the first day of the person’s admission. MDHHS codes the MI Choice participant's last day in LOC 22 on the day before the nursing facility admission. One day before admission to a nursing facility is the last date of MI Choice enrollment. There are no exceptions to this requirement. When a nursing facility discharges a MI Choice participant, MDHHS may restart the LOC 22 on the date of the discharge. Waiver agencies confirm MI Choice re-enrollment with the MDHHS Field Office for participants re-entering the MI Choice program after a nursing facility admission. Waiver agencies must complete a new NFLOC determination and enter the new determination in the on-line system according to established MSA policy upon each reenrollment, including reenrollments after a nursing facility admission. With proper planning, waiver agencies may initiate MI Choice services the same day as a nursing facility discharge.

As of January 2, 2018, when a MI Choice participant is admitted to a nursing facility, the waiver agency will enter the disenrollment information in CHAMPS. The MI Choice end date will be the day before the nursing facility admission. Waiver agencies are encouraged to verify nursing facility admission dates with the nursing facility. When a previous MI Choice participant is discharged from the nursing facility, the waiver agency may reenroll the participant on the day of the nursing facility discharge through the enrollment process in CHAMPS. This change does not affect the NFLOC determination requirements.

4. Hospital Admissions

A hospital admission is not an enrollment in a LOC service. Generally, waiver agencies do not provide MI Choice services, other than SC and possibly continuation of a personal emergency response system, to participants while hospitalized.

A MI Choice participant admitted to a hospital may remain enrolled in MI Choice for up to 30 days. The waiver agency must provide the participant with an adequate action notice upon notification of a hospitalization if it is necessary for the agency to suspend MI Choice services during the hospitalization. When the participant is hospitalized for less than 30 days, the participant's services may restart upon discharge from the hospital. If the participant is discharged after 30 days, the participant may re-enroll in MI Choice using standard enrollment procedures. If a participant is admitted to a nursing facility from a hospital before the 30th day of hospital stay, the last MI Choice eligibility date is the day before the date of nursing facility admission.

5. Enrollment in MI Health Link

Individuals enrolled in MI Health Link cannot also enroll in MI Choice. Refer individuals to a Medicare/Medicaid Assistance Program counselor for options counseling before deciding to opt-out or disenroll from MI Health Link. Michigan ENROLLS handles all enrollments, disenrollments and opt-outs for MI Health link. All MI Health Link

disenrollments are effective on the last day of a month. Normally this is the last day of the month of request. For requests made later in the month, the disenrollment may not take effect until the last day of the month following the month of request. Eligible individuals may enroll in MI Choice after the effective date of the MI Health Link disenrollment.

MI Health Link has nine PET codes depending upon the living arrangement of the individual. The PET codes and description are as follows:

ICO-COMM: Enrolled in MI Health Link and residing in the community
ICO-HCBS: Enrolled in the MI Health Link HCBS Waiver and residing in the community
ICO-NFAC: Enrolled in MI Health Link and residing in a nursing facility (not a County Medical Care Facility)
ICO-CMCF: Enrolled in MI Health Link and residing in County Medical Care Facility
ICO-HOSH: Enrolled in MI Health Link and receiving hospice at home
ICO-HOSR: Enrolled in MI Health Link and residing in hospice residence facility
ICO-HOSW: Enrolled in MI Health Link HCBS Waiver and receiving hospice services at home
ICO-HOSN: Enrolled in MI Health Link and receiving hospice services in a nursing facility
ICO-HOSC: Enrolled in MI Health Link and receiving hospice services in a County Medical Care Facility

Waiver agencies will need to coordinate enrollments with the MI Health Link discharge to ensure the proper MI Choice PET sets on the day of MI Choice enrollment. MI Health Link discharges will be effective on the last day of the month. Therefore, MI Choice should not enroll until the first day of the following month.

C. MI CHOICE ENROLLMENT NOTIFICATION TO THE MDHHS FIELD OFFICE

The waiver agency notifies the MDHHS Field Office of MI Choice participant enrollment and disenrollment dates, as well as subsequent changes made to MI Choice enrollment and disenrollment dates.

Requirements after January 2, 2018

1. Waiver agencies must enter all enrollments in CHAMPS. MSA Policy Bulletins 17-40 and 17-46 define this process. Waiver agencies must enter enrollments in CHAMPS within five days of knowing and verifying the actual date of enrollment. If the enrollment date changes, the waiver agency must contact the appropriate MDHHS staff to make a correction.
2. Waiver agencies must enter all participant disenrollments in CHAMPS within five days of knowing and verifying the actual disenrollment date. The MI Choice end date is the last day of the participant's enrollment in MI Choice.
3. When the waiver agency needs to change a previously reported MI Choice start (enrollment) or stop (disenrollment) date, the waiver agency must notify MDHHS staff of the new date and the reason for altering the original date.
4. The participant’s record must clearly identify all enrollment and disenrollment dates for MI Choice participants.
5. Waiver agencies must develop processes for confirming PET enrollment and disenrollment dates and verifying these dates correspond with Waiver-Yes dates in their Health Information Systems.

B. PARTICIPANT PROGRAM CLASSIFICATION AND STATUS TYPE

Most waiver agencies have more than one funding source for services provided by the agency. Waiver agencies utilize MICIS, COMPASS, or a compatible data system to track several types of care management programs. Waiver agencies assign a Program Classification Type to participant data records to permit accuracy in reporting and to avoid unnecessary duplication of participant counts within various Medicaid and non-Medicaid funded LTSS programs. Restrictions in LOC coding, PET coding, and MI Choice program

eligibility may make it necessary to change a participant's program classification among care management program types.

1. Program Classifications

The following participant program classifications are used in Michigan's Data Warehouse Database:

a) **WA = Waiver**

The participant is or is expected to be eligible for and enrolled in MI Choice.

b) **OSA/CM = State Funded Care Management through AASA**

The participant is enrolled in the AASA Care Management Program.

c) **TCM = Targeted Case Management**

The participant is enrolled in the AASA Care Management Program and meets community Medicaid and NFLOC criteria.

d) **CC = Case Coordination**

The participant is enrolled in Area Agency on Aging (AAA)-funded case coordination services. Medical eligibility for a NFLOC is not required.

e) **CCC = Community Care Coordination**

The participant is enrolled in a community care coordination service funded by a variety of community sources. Medical eligibility for a NFLOC is not required.

f) **LCM = Local Care Management**

Participant is enrolled in a locally funded care management service.

g) **LCCC = Local Community Care Coordination**

Participant is enrolled in a locally funded community care coordination service. Medical eligibility for a NFLOC is not required.

h) **NFTI = Nursing Facility Transition (Initiative)**

Participant is currently residing in a nursing facility, the waiver agency has assessed them, and the participant has agreed to have waiver agency assist with transitioning to the community.

i) **PP = Private Pay Case Management**

Private Pay case management classification types are used when participants pay directly for the cost of services and may be tracked in MICIS, COMPASS, or a compatible data system.

j) **CR = Caregiver Respite**

Funds provided from Tobacco Settlement Funds to be used to distribute funding for the caregiver respite service. These may be tracked in MICIS, COMPASS, or a compatible data system for eligibility and case status, following assessments, and managing program classifications and status changes.

k) **WFI = Waiver Financially Ineligible**

The waiver agency presumed eligibility for the participant, the MDHHS Field Office later denied financial eligibility.

2. **Waiver Eligible Status Classifications**

a) **Y (Yes)**

The participant meets NFLOC criteria, the MDHHS Field Office determined financial eligibility, the participant requires at least one MI Choice service in additional to supports coordination and the participant agrees to enroll in MI Choice.

b) **N (No)**

The participant is not enrolled in or does not qualify for MI Choice.

c) **P (Pending)**

The participant meets NFLOC and requires at least one MI Choice service in addition to supports coordination, but the waiver agency is awaiting confirmation of financial eligibility from the MDHHS Field Office. Waiver agencies can use the “Pending” status only when the Medicaid application has been completed and submitted to the MDHHS Field Office, and the waiver agency has preliminarily determined (presumed) the participant is likely to meet financial eligibility requirements.

d) **I (Ineligible**)

The participant did not meet at least one of the eligibility criteria for MI Choice.

3. Transition/Diversion Case Status

a) No

The participant was not transitioned from the nursing facility.

b) Diverted

The participant met Imminent Risk Criteria as approved by MDHHS in the NFT Portal and has enrolled in the MI Choice program.

c) Transitioned

The waiver agency submitted and MDHHS approved the appropriate information in the NFT Portal, the participant transitioned from a nursing facility, and the participant has enrolled in the MI Choice program.

d) Exception

The waiver agency submitted and MDHHS approved the appropriate information in the NFT Portal, the participant transitioned from a nursing facility, the participant has enrolled in the MI Choice program, AND MDHHS approved an "under six months" or "other" exception in the NFT portal for the participant. ***MDHHS no longer uses nor requires this classification.***

e) NFT Buddy

The waiver agency submitted and MDHHS approved the appropriate information in the NFT Portal, the participant transitioned from a nursing facility, the participant resided in a nursing facility for less than six months, and the participant has enrolled in the MI Choice program. ***MDHHS no longer uses nor requires this classification.***

4. Money Follows the Person (MFP)

a) "Yes" indicates the person has transitioned from the nursing facility or other institution and MDHHS has verified the participant meets all other criteria for inclusion in the MFP Program as specified in the NFT portal.

b) **"No"** indicates this person does not qualify for the MFP Program, or has exceeded the 365 waiver-day limitation of enrollment in this program.

5. **Self-Determination (SD)**
   a) **"Yes"** indicates the participant is enrolled in the MI Choice program and has chosen the self-determination option for delivery of services.
   b) **"No"** indicates the participant has not chosen the self-determination option for the delivery of services.

6. **Memorandum of Understanding (MOU)/Special Memorandum of Understanding (SMOU)**
   a) **"No"** indicates the participant does not qualify for a MOU or a SMOU
   b) **"MOU"** indicates this person qualifies for a MOU. ***MDHHS no longer uses nor requires this classification.***
   c) **"SMOU"** indicates this person meets the significant support participant criteria for the purposes of capitation rates as specified in Attachment Q.

7. **Case or Open Status Classifications**
   a) **"A"** indicates the participant is on open maintenance status.
   b) **"0"** indicates the participant is on open active status.

<u>Requirements</u>

1. The waiver agency is responsible for confirming participant case classifications for program participants and to monitor the accuracy of participant data records.
2. **Waiver agencies must track MI Choice eligibility dates and statuses accurately in MICIS, COMPASS, or a compatible database.**
3. Participants have one program classification, eligibility, transition, MFP, self-determination, and case status classification during a single duration of time.
4. Waiver agencies have written procedures to establish program status for MI Choice participants and to maintain and monitor the accuracy of participant data records.

5. When a waiver agency uses "Pending" waiver eligible status classification, the waiver agency must provide the participant with the full array of MI Choice services as specified in the PCSP. When the MDHHS Field Office confirms the participant's eligibility for Medicaid, the waiver agency may then reclassify the participant with "Yes" waiver eligibility status. The waiver agency may choose to begin the "Yes" waiver eligibility status from either the MI Choice assessment date or the start date of MI Choice services when the MDHHS Field Office grants Medicaid eligibility retroactive to the assessment date. If Medicaid eligibility begins after the assessment date, the waiver agency must use the first date of Medicaid eligibility as the start date of "Yes" waiver eligibility status.
6. When the waiver agency is unable to presume financial eligibility for the participant, the agency must use the "Ineligible" waiver eligibility status classification. The waiver agency cannot begin MI Choice services until it receives confirmation from the MDHHS Field Office of the participant's eligibility for Medicaid. When the MDHHS Field Office confirms the participant's eligibility for Medicaid, the waiver agency may then reclassify the participant with "Yes" waiver eligibility status. The waiver agency may choose to begin the "Yes" waiver eligibility status from either the date of the MDHHS Field Office notification of Medicaid eligibility or the start date of MI Choice services.
7. Waiver "Pending" status should not remain on closed cases. Once a case is closed, and the MDHHS Field Office has made a Medicaid determination, the participant was either waiver eligible or not. The eligibility is no longer "Pending". Waiver agencies must have policies and procedures in place for periodically reviewing all participants with Waiver "Pending" status and making adjustments to that status as indicated. Waiver "Pending" is only used for participants whose eligibility status has not yet been determined.

C. NURSING FACILITY ADMISSIONS FROM MI CHOICE

The waiver agency reimburses MI Choice service providers for services furnished to a MI Choice participant as authorized on the same day, immediately before, a participant's admission to a nursing facility.

D. TRANSFERRING MI CHOICE PARTICIPANTS TO ANOTHER WAIVER AGENCY

MDHHS ensures participants have a choice of a waiver agency, as available, to coordinate MI Choice services. A participant may choose to transfer enrollment from one waiver agency to another, as available within the region where he or she lives, or a participant may move to another region of the state. Waiver agencies are responsible for managing transfers of participants to other agencies or accepting transfers from another agency.

Requirements

1. Waiver agencies ensure that participants are transferred from one agency to another, preserving continuity of care and the integrity of the participant's preferences and person-centered plan.
2. The new waiver agency should perform an initial assessment and make a NFLOC determination. The new waiver agency must enter a NFLOC Determination in the online system for the transferred participant within 14 calendar days after the date of the participant's enrollment in the new waiver agency's program or otherwise according to MDHHS NFLOC Determination policy.
3. The new waiver agency for each transferred participant must not reimburse providers for delivered MI Choice services authorized by a previous waiver agency. The new waiver agency reviews PCSP activity and authorizes a new PCSP with the participant.
4. The waiver agency the participant transferred from is responsible for closing the participant enrollment at that agency and with the MDHHS Field Office so that the new agency can enroll the participant in its MI Choice program. As of January 2, 2018 the waiver agency the participant transferred from is responsible for entering disenrollment information in CHAMPS so that the waiver agency the participant is transferring to may enter enrollment information in CHAMPS.

II. PARTICIPANT CARE PLANNING

A. GENERAL INFORMATION

SCs, supports brokers, or designated PCP facilitators work with each participant and their allies to develop a written PCSP. The PCSP must reflect the services and supports important for the individual to meet the needs identified through the iHC assessment, and what is important to the individual regarding preferences for the delivery of services and supports. This plan also documents planned services, supports, and interventions. The plan describes the medical and other services related to the participant's LTSS needs and preferences (regardless of funding source) to be furnished to the participant. Care planning includes the authorization of services.

SCs inform the participant or his or her representative of all available options to address identified issues and needs. The SC, supports broker, and the participant concur upon the services and supports arranged, as well as the frequency and duration of those services.

Requirements

1. At minimum, the participant PCSP includes:

- **a)** An indication that the participant chose the setting in which the participant resides. The waiver agency ensures the setting chosen by the participant is integrated in, and supports full access to the greater community. This includes opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not enrolled in MI Choice.
- **b)** The individual's strengths and preferences.
- **c)** The clinical and support needs as identified through the iHC assessment.
- **d)** Individually identified goals and desired outcomes.

e) The services and supports (paid and unpaid) that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural and informal supports.

f) Risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.

g) Language that is understandable to the participant, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of Chapter 42 of the Code of Federal Regulations.

h) The individual or entity responsible for monitoring the plan.

i) Finalization and agreement by the participant, with the participant's written informed consent, and dated signatures of all individuals and providers responsible for its implementation.

j) Distribution to the individual and other people involved in the plan.

k) All self-directed services.

l) Only necessary or appropriate services and supports.

m) Documentation of any modification to the additional conditions related to qualified home and community based settings supported by a specific assessed need and justified in the person-centered service plan. For **each** modification, the following requirements must be documented in the person-centered service plan:

(1) A specific and individualized assessed need.

(2) The positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) The Less intrusive methods of meeting the need that have been tried but did not work.

(4) A clear description of the condition that is directly proportionate to the specific assessed need.

(5) A regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) The informed consent of the individual; and

(8) An assurance that the interventions and supports will cause no harm to the individual.

2. Participants are actively involved in the plan's development and must approve each service or intervention before implementation or as desired by the participant.

3. Waiver agencies have policies and procedures to define the development and approval of the PCSP that include a requirement that the PCSP addresses all needs and goals identified from the most recent assessment.

4. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the participant's condition or disease. For MI Choice services, supports coordinators or the supervisor of a supports coordinator would have this clinical expertise.

5. Participants may provide oral approval of the PCSP. The SCs must document the oral approval, including the date received on the PCSP and secure the participant's signature during a subsequent in person encounter. This permits waiver agencies to begin service delivery after participant approval, but before securing the participant's signature. This requirement does not conflict with or negate requirements contained in #2 above.

6. Waiver agencies establish written procedures to ensure that services are initiated in a timely manner. The QMC recommends a benchmark for "timely" for this process as within seven days of MI Choice enrollment for each participant. Procedures are to include how the waiver agency coordinates services with participants with a pending financial eligibility status. Participants may receive services before the determination of financial eligibility when financial eligibility appears imminent.

7. The PCSP may include CAPs for each protocol triggered related to a specific PCSP item when the CAPs are applicable to the participant and the participant agrees with the proposed action. Not all CAPs triggered are applicable to each participant, and a participant may state that they do not wish to include specific CAPs on their PCSP. SCs should use CAPs and triggers as a tool for developing a comprehensive PCSP. However, the SCs should never restrict the PCSP to only those CAPs triggered by the participant's assessment.
8. The PCSP reflects the SC's authorization to implement participant-approved services. The SC updates the PCSP as frequently as necessary or preferred, but at least every 90 days after the initial assessment, then 180 days after that or as desired by the participant and documented in the PCSP.
9. In its entirety, the PCSP includes all of the services and supports provided to meet the needs of a participant, including services funded from sources other than MI Choice. This includes services obtained through allies, Medicare, the State Medicaid plan, other public programs, and/or paid and unpaid supports that meet identified participant needs.

B. PARTICIPANT MANAGEMENT OF RISK

Participant management of risk embraces all the decisions one makes and activities one undertakes with the intent of improving one's health and safety and the environment. Each risk involves the possibility of detrimental consequences and their likelihoods. The management component of risk management involves decisions about these risks. State and federal government legislation and regulations make thousands of such decisions; families and individuals make millions of these decisions (National Quality Inventory Project, MS HCBS Waiver Programs for Individuals with Developmental Disabilities., Glossary, p. 121). In MI Choice, effective risk management builds upon the service planning and monitoring processes.

CMS and MDHHS require waiver agencies to assist MI Choice participants in managing the risks associated with choosing home and community-based service programs over

institutionalization. Risk management is part of assuring the health and welfare of MI Choice participants. "The identification of potential risks to waiver participants and the development of strategies to mitigate such risks are integral to enabling participants to live as they choose in the community while assuring their health and welfare. Critical risks should be addressed during the PCSP development process by incorporating strategies into the plan to mitigate whatever risks may be present" (CMS Instructions, Technical Guide and Review Criteria, Version 3.5 HCBS Waiver Application, p. 183). According to *Risk Management and Quality in HCBS: Individual Risk Planning and Prevention, System-Wide Quality Improvement*, a 2005 report funded by CMS, risks and the need to manage them are part of providing community-based services and supports to people with disabilities and the elderly.

The SCs identify potential risks to the participant during all assessments and fully discusses these risks with the participant and their allies upon identification. During the PCP process, the participant specifies risks and preferred methods of monitoring their potential impact. Some participants may be in at-risk situations because of the absence of scheduled services that put the participant in a vulnerable state by compromising his or her health and welfare. Other risk situations include (but are not limited to) a structurally damaged or unsanitary environment or non-compliance with medical care. The iHC assessment system will automatically elicit some participant risks through the CAPs and triggers reports.

Waiver agencies may require participants to acknowledge when their choices pose risks for their health and welfare. MDHHS does not obligate the waiver agency to authorize services believed to be harmful to the participant. The SCs initiate negotiations of such issues in the PCP process. The SCs educate the participant to ensure the participant makes informed choices concerning their risks. The SCs inform service providers of a participant's risk status when ordering services in the traditional MI Choice program. The participant or, if preferred, the SCs inform service providers of the participant's risk status when the participant chooses the SD in LTC option. MDHHS requires agency providers,

including waiver agencies, to have a contingency plan for emergencies that pose a serious threat to participant health and welfare (i.e., inclement weather, natural disasters, and unavailable person caregiver.)

Each PCSP describes back-up plans to implement when selected service providers are unable to furnish services as planned. This may involve developing lists of alternative qualified providers, using a provider agency or informal supports, or contacting the SC when planned services are unavailable. Additionally, the waiver agency develops an emergency plan with each participant that clearly describes a preferred course of action when the participant has an emergency. SCs discuss and incorporate contingency plans into the individual PCSP during the PCP process.

MDHHS staff reviews a random sample of contingency plans during the CQAR to assure they meet participant needs and there is proper documentation for emergency, back up planning, and risk management procedures. The MI Choice Quality Improvement Strategy requires waiver agencies to monitor and track the activation of back-up plans, including how well the plans worked in an effort to improve the development of back-up plans with participants.

1. Clinical Assessment Protocols (CAPs) and Triggers

The iHC includes 27 CAPs that contain general guidelines for further assessment and individualized planning for participants when the iHC indicates problematic or "trigger" conditions. The iHC items identify participants who could benefit from further evaluation of specific problems and risks for functional decline. These items, known as triggers, link the iHC to a series of problem-oriented CAPs. Inter-RAI designed all CAPs to inform the clinical process. An average participant may trigger 10-14 of the 27 CAPs. Some of the CAPs form the core of the PCSP when relevant to the participant's existing problems and risks, others will not.

Waiver agencies may use a computerized report called the CAPs and Triggers Report (C&T report) that generates following each assessment of a participant. SCs use the information on the C&T report to identify problems, evaluate causes and associated conditions for the problems, and to assist in the development of necessary goals and related approaches to services and referrals for services and supports. C&T reports also assist SCs with addressing and managing risks based upon the participant's identified individual risk factors. The in-depth evaluation of problems following the routine assessment helps SCs think through why a problem exists or why the participant is at risk, providing the necessary foundation on which to base the next steps in care planning to reduce risk.

The review of the C&T report requires SCs to evaluate a wide variety of triggered problems. The focus is not just on simple maintenance services or planning a response to an immediate problem. While these are included, the system also helps SCs to assess for opportunities to rehabilitate function, prevent decline, and maintain participant strengths. In responding to urgent needs, the participant and their SCs can identify service and support priorities. In looking at chronic problems, the participant and their SCs can maintain comprehensive well-being. All risk planning and management is contingent on the participant and families agreeing with the assessment and SC recommendations in care planning.

It is important to note that not all conditions triggered apply to every participant. The SC or participant may have already planned for, ameliorated, or determined a specific condition is not a problem to the participant. Conversely, the CAPs do not include every problem that the participant needs to have addressed in care planning and risk management. However, the CAPs are sound starting points covering most frequent problem situations that SCs need to address in care planning and risk management.

2. Service Need Levels Based on Identified Risks

a) SCs fully discuss strategies to mitigate risk with the participant and their allies, family, and relevant others during PCP.

b) The SCs inform the participant of risks and educate the participant about consequences of chosen risks, as necessary. SCs document the participant's informed choice in the case record.

c) SCs document participant-approved risk strategies and write them into the PCSP.

d) When a participant makes decisions that are self-injurious or jeopardize the safety of others, SCs determine if an appropriate substitute decision-maker can act informally or if they should seek a guardian to protect the participant. Waiver agencies must define a local procedure for taking such action.

e) SCs identify the service need level of each participant according to the standard service need levels described in Attachment H of the MI Choice contract and document the participant’s service need level in the PCSP.

f) SCs inform service providers of a participant's service need level when ordering services.

g) MDHHS requires direct providers of MI Choice services to have a contingency plan for emergencies that pose a serious threat to participant health and welfare (i.e., inclement weather, unavailable personal caregivers, etc.).

h) Waiver agencies maintain policy and procedures that address the use of restraints and seclusion of participants. SCs do not encourage the use of restraints by allies, but educate allies regarding alternative methods to address issues. Waiver agencies establish procedures that include:

(1) The use of alternative methods to avoid the use of restraints and seclusion;

(2) Methods used by SCs to detect the use of restraints;

(3) The protocols that SCs, service providers, and allies must follow when the use of restraints or seclusion are identified;

(4) The practices that must be employed to ensure the health and welfare of individuals; and

(5) Documentation that is required concerning the use of restraints or seclusion.

3. Contingency Planning

The development of contingency plans is one way to address some of the risks encountered by MI Choice participants. MDHHS identifies both emergency plans and backup plans as contingency plans for MI Choice participants. Contingency plans may be a single document that incorporates both the emergency plan and the backup plan.

a) Requirements

(1) Waiver agencies assist all participants in the development of an effective contingency plan crafted to meet the unique needs and circumstances of each MI Choice participant.

(2) Waiver agencies must use the service need levels as required in Section II.A of the Minimum Operating Standards for MI Choice Waiver Program Services and notify contracted providers of this system.

(3) Waiver agencies retain a copy of each participant's contingency plan in the participant record and provide additional copies to the participant, service providers, and other allies included in the plan, as preferred by the participant.

(4) The contingency plan is updated as needed and the waiver agency sends the participant, service providers, and other allies a copy of the contingency plan after each update.

b) Emergency Plans

(1) An emergency is a situation or event that places your health or life in danger and requires immediate action or medical attention to prevent physical harm or hospitalization. Emergencies include natural disasters (tornados, floods, drought, heat waves, blizzards, etc.), unnatural disasters (fires, bomb threats, terrorism, etc.), and sudden onset of medical crises.

(2) The waiver agency encourages participants to use a personal emergency response system (PERS) or dial "911" during an emergency.

(3) Participants whose life depends upon equipment that requires electricity have an emergency plan that addresses what to do during a power outage, or clearly states the participant's preference not to include such measures.

(4) Participants who need assistance to ambulate have an emergency plan that includes the notification of someone that will assist them in evacuating their residence if necessary, or clearly state the participant's preference not to include such measures.

(5) MDHHS urges all participants to have escape routes defined for various disasters.

(6) MDHHS urges all waiver agencies to be involved with law enforcement officials and other disaster preparedness agencies at the local level to help these agencies identify and assist MI Choice participants during emergencies.

c) Backup Plans

(1) Backup plans provide for alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails or is unable to deliver them (CMS Instructions, Technical Guide, and Review Criteria, Version 3.5 HCBS Waiver Application, p. 183). Backup plans are employed when scheduled providers do not show up as anticipated.

(2) Each contracted service provider shall have established policies and procedures that reasonably assure the delivery of services to participants in the event that the regularly scheduled employee is unable to furnish the service.

(3) In accordance with the Minimum Operating Standards for MI Choice Waiver Program Services, Section II.A, the waiver agency notifies providers of the participant's service need level. This information shall also be included on the backup plan for each participant.

(4) Backup plans should minimally include contact information for all providers furnishing critical services to the participant. A critical service is a service the

participant must receive as planned and as specified in the service need level of the participant.

(5) Backup plans should include methods for the participant and provider agency to contact the SC if a provider does not deliver a service as planned.

(6) Backup plans should include provisions for furnishing services when an unpaid caregiver is unable to provide a service that is critical to the participant and usually provided by that ally.

(7) Backup plans should clearly state the participant's preferences for receiving services and supports if the regularly scheduled person cannot furnish the services and supports.

(8) Waiver agencies develop policies and procedures to track the following:

(a) When backup plans are activated;

(b) When the backup direct service provider furnished services; and

(c) When service is not provided following activation of backup plans.

C. PERSON CENTERED SERVICE PLANS and SERVICE ORDERS

As a component of person-centered planning, waiver agencies develop PCSPs. At a minimum, the participant PCSP includes:

1. Purchased MI Choice services;

2. Frequency and duration of each service, i.e., number of hours/day and days/week that service will be provided for estimated duration;

a) Days per week should be as specific as possible.

b) Altering or adjusting the days per week is possible, based on participant preference, and SCs may note this in the service plan.

c) For some services, such as chores (snow plowing & lawn mowing), days per week can be defined as "when needed." If a PCSP states, "When needed," the waiver agency must define when the participant needs such services, i.e. three or more inches of snow, grass is four inches or higher, etc.

3. Units of each service per visit and per week;

4. Cost per unit;
5. Total cost of service plan;
6. Start and stop dates for each service; and
7. Provider of each service.

D. INVOLVEMENT OF ALLIES

SCs work with participants to engage a team of family, friends, professionals, supports brokers, caregiver staff, and other allies to assist in the development of plans of service and to strengthen the skills of participants to address planned activities. Generally, MI Choice services are not used to replace existing unpaid supports, but rather bolster and help sustain ongoing allies' involvement.

E. USE OF OTHER PAID SERVICES

Before authorizing MI Choice services for a participant, the waiver agency must take full advantage of services and supports in the community that are available to the participant and paid for by other fund sources, including third party reimbursements and the Medicaid State Plan services. MI Choice funding is the payment source of last resort in most circumstances.

F. THIRD PARTY LIABILITY (TPL)

The waiver agency pursues and secures all TPL sources possible. Waiver agencies make every effort to enroll and utilize dually certified Medicare/Medicaid providers for counseling, training, private duty, and nursing services to maximize Medicare payment for services also available through MI Choice. Other TPL sources include the Veteran's Administration, Medicare skilled home health services, the Medicaid State plan, and other sources of LTSS available to participants.

G. WAIVER AGENCY GRIEVANCE AND APPEAL SYSTEM RESPONSIBILITIES

All Medicaid applicants and recipients have the right to a fair hearing. Waiver agencies, as a Medicaid managed care provider, have certain responsibilities related to the rights of persons applying for or receiving MI Choice services. This includes providing the

applicant or participant with appropriate notice of their right to request an appeal when the waiver agency takes an adverse action against them, or a grievance when they are dissatisfied with the quality of services received. For applicants and participants of MI Choice, an adverse action occurs when, but is not limited to, situations where the waiver agency does any of the following:

1. Suspends or terminates participation in MI Choice;
2. Denies an applicant's request for participation in MI Choice;
3. Reduces, suspends, terminates, or adjusts MI Choice services currently in place;
4. Denies an applicant's or participant's request for MI Choice services that are not currently provided; or
5. Denies a participant's request for additional amounts of currently provided services.

CMS requires managed care providers to send an Adverse Benefit Determination notice to MI Choice participants when the waiver agency makes decisions regarding their access to MI Choice services. Each Adverse Benefit Determination sent to the participant must be in writing and meet the language needs of the individual so the recipient understands the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency). Attachment C of the MI Choice contract specifies requirements for the waiver agency's Grievance and Appeal system, including time frames for making decisions and the individual's right to a Medicaid Fair Hearing after exhausting the waiver agency's process.

III. SERVICE ARRANGING

SCs perform the service arranging function from the PCSP to the extent desired by the participant. SCs arrange or purchase services and supports by authorizing participant-selected service providers to deliver planned services. Waiver agencies have written procedures regarding how SCs arrange services and assist participants in selecting a provider to furnish services.

Requirements

1. SCs serve as consultants to the participant's personal physicians and secure approval for service when plans of service specify arranging services or supports that require physician approval or authorization.
2. Waiver agencies establish selection criteria to assist in arranging services from competing providers.
3. Waiver agencies complete a written service authorization, linkage form, services order form, or work order and submit it to contracted service providers for each service arranged or purchased. The service authorization specifically documents the service(s) to furnish, delivery times, and specific tasks the caregiver should perform during service delivery for the selected provider. The form may document participant preferences related to service delivery. Service authorizations also document adjustments to the PCSP, i.e., increases, reduction in frequency, new services, or service cancellation.

IV. PURCHASED SERVICES

A. GENERAL INFORMATION

The waiver agency establishes written procedures for the purchase of waiver-funded services. Contracts assure that qualified providers receive full reimbursement for services furnished according to the PCSP.

Requirements

1. Waiver agencies have policies and procedures to identify and prevent problems with access to MI Choice services. Access issues include, but are not limited to, problems with provider availability and adherence to the participant approved service plan.
2. Waiver agencies and service providers enter into contractual agreements that include required assurances for nondiscrimination, minimum provider service standards, and contract requirements included in 42 CFR 434, 42 CFR 438, and the MSA provider enrollment agreement.
3. The waiver agency maintains written minimum service standards for MI Choice services that fulfill licensure and certification requirements mandated by CMS and that

comply with the CMS-approved MI Choice waiver application and the MDHHS Minimum Operating Standards for MI Choice Services.

4. The waiver agency has written procedures to secure competitive, per unit rate agreements from qualified service providers.
5. Each waiver agency uses an open bid process to contract with qualified providers in their service area that are willing to furnish MI Choice services. MDHHS requires each waiver agency to have a provider network with capacity to serve at least 125% of their monthly slot utilization for each MI Choice service, and at least two providers for each MI Choice service. This assures network capacity as well as choice of providers. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from the MDHHS.
6. The provider enrollment process includes a description of the frequency and method of verifying and monitoring staff qualifications and how the waiver agency documents this verification. MDHHS defines a willing provider as a provider who agrees to accept Medicaid payment as payment in full for rendering a service, abide by all other Medicaid provider requirements, including executing provider agreements, and adhere to the required service standards.
7. Waiver agencies must allow Medicaid beneficiaries to select from any qualified provider within the waiver agency's provider network.
8. Waiver agencies must provide MI Choice services to any participant who needs the service. Waiver agencies may not limit the number of MI Choice participants who receive a service or deny a needed MI Choice service for any reason (e.g., lack of funds). Waiver agencies must make MI Choice services available on a comparable basis to all MI Choice participants based on need.

B. ENROLLMENT OF SERVICE PROVIDERS

The waiver agency is responsible for securing qualified service providers to furnish MI Choice services. Eligible provider applicants include public, private, non-profit, or for-profit organizations that provide services that meet MI Choice service standards, certifications, and/or licensure requirements.

Waiver agencies mail provider application packages to potential service providers or make them available on the waiver agency's website. Provider applicants complete and submit an agreement and assurance forms to the waiver agency. The waiver agency reviews all applicants' requests to determine that providers are qualified to furnish requested MI Choice service(s) before rendering participant services.

After the waiver agency reviews and verifies service provider qualifications, the waiver agency enrolls the provider as a Medicaid provider using the agreement and the Medicaid Provider Enrollment agreement. The waiver agency maintains signed and executed agreements on file at the waiver agency.

C. REQUIRED INSURANCE

Service provider agencies show proof of sufficient insurance coverage to indemnify loss of federal, state, and local resources due to casualty or fraud, and to cover the fair market value of the asset at the time of loss. The waiver agency requires the following insurance coverage for each service provider agency, as applicable:

1. Workers Compensation;
2. Unemployment;
3. Property and theft coverage;
4. Fidelity bonding (for persons handling cash);
5. Facility insurance (for facilities purchased with federal and/or state funds); and
6. No-fault vehicle insurance (for agency owned vehicles.)

D. SELECTION OF A PROVIDER TO FURNISH SERVICES

The waiver agency works with participants to select service providers as needed on an individual basis according to the following criteria:

1. Participant Preference: Participant has a provider preference.
2. Cost: The cost of services is a factor in selecting a service provider.

3. Accessibility: Practical considerations involved in selecting a provider include the provider's geographic area of service and ease of service delivery to the participant.
4. Ability to provide quality service: The waiver agency considers the provider's past performance in furnishing quality services as authorized in the participant PCSP. Quality includes performance, participant outcome, and accountability as monitored by the waiver agency.
5. Comprehensive Care: The waiver agency makes a reasonable effort to minimize the number of different agencies involved in providing services to each participant, to limit participant and family stress. The waiver agency considers the ability of the provider to furnish the different types of services needed by each participant when ordering services.

Requirement

1. Waiver agencies have policy and procedures for identifying, documenting, and addressing noncompliance by providers. This includes identification of the persons responsible for taking appropriate action with providers who continually demonstrate poor performance or who are not qualified to provide services.

E. WAIVER SERVICE DEFINITIONS

CMS approved the following MI Choice services for inclusion in the waiver participant's PCSP:

1. **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 PCSP, 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.
2. **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, securing 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.

3. **Community Health Worker:** The Community Health Worker (CHW) works with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assists the participant with obtaining assistance in the community.
4. **Community Living Supports:** Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it shall not also be authorized as a separate waiver service for the beneficiary.
5. **Community Transition Services:** Community Transition Services (CTS) are non-reoccurring expenses for persons transitioning from a nursing facility to another living

arrangement in a private residence where the person is responsible for his or her own living arrangement.

6. **Community Transportation**: The Community Transportation (CT) service combines non-emergency medical transportation and non-medical transportation into one transportation service. CT 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. The CT service may also be utilized for expenses related to transportation and other related travel expenses determined necessary to secure medical examinations/appointments, documentation, or treatment for participants. **Counseling:** Professional level counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems and/or change in an individual's social situation.

7. **Environmental Accessibility Adaptations:** Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's PCSP 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. Assessments and specialized training needed in conjunction with the use of such EAAs are included as a part of the cost of the service.

8. **Fiscal Intermediary Services:** Fiscal Intermediary services assist participants in self-determination in acquiring and maintaining services defined in the participant's PCSP, 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 PCSP. 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 review checks, and assisting the participant to understand billing and documentation requirements.

9. **Goods and Services:** Goods and services are services, equipment, or supplies not otherwise available through the MI Choice waiver or the Medicaid State Plan that address an identified need in the individual PCSP, including improving and maintaining the participant's opportunities for full membership in the community.
10. **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 a selected congregate meal site that provides a minimum of one-third of the current recommended dietary intake (RDI) 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 PCSP. HDMs cannot constitute a full nutritional regimen.
11. **Nursing Services:** MI Choice Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse (RN). MI Choice Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services shall not duplicate services available through the Medicaid State Plan or third payer resources.

12. **Personal Emergency Response System (PERS):** 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.
13. **Private Duty Nursing (PDN)/Respiratory Care:** Private Duty Nursing (PDN)/Respiratory Care 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/RC includes the provision of nursing/respiratory care assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act or respiratory therapists, consistent with physician's orders and in accordance with the participant's PCSP. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance. PDN for a participant between the ages of 18-21 is covered under the Medicaid State Plan.
14. **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.
15. **Specialized Medical Equipment and Supplies:** Specialized Medical Equipment and Supplies includes devices, controls, or appliances that enable participants to increase

their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items. This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. 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.

16. **Supports Coordination:** Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's PCSP. 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.
17. **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 PCSP. 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, training, and supervision, or other areas related to self-direction.

F. USE OF REGULAR MEDICAID STATE PLAN SERVICES

The waiver agency does not purchase MI Choice services to replace services currently offered under the regular Medicaid state plan. Examples include: medical supplies and medical equipment. The waiver agency does not pay additional monies above the Medicaid allowable cap for services covered by the regular Medicaid state plan.

G. PRIOR AUTHORIZATION OF MEDICAID STATE PLAN SERVICES

Waiver agencies request that medical suppliers and equipment dealers seek approval for Medicaid payment of those items covered under the Medicaid State plan with prior authorization required. A Medicaid Durable Medical Equipment (DME) provider must furnish medical equipment and medical supplies covered under the Medicaid State Plan. Waiver agencies cannot expend MI Choice funds on Medicaid State Plan covered services. SCs may assist the Medicaid DME provider by helping them to obtain the required paperwork and medical reports before submission of the prior authorization request.

H. WAIVER AGENT BILLING AND PAYMENTS

1. Billing Procedures

a) Providers of MI Choice services submit bills to the waiver agency detailing the date of service, the type of service, the unit cost, and the total number of units provided for each MI Choice participant served.

b) Waiver agencies specify in provider contracts the acceptable amount of time from date of service that providers may send bills to the waiver agency in order to receive payment for services rendered.

c) Waiver agencies match and verify provider bills against the participant's approved PCSP using MICIS, COMPASS, or a compatible data system.

d) Waiver agencies have written procedures regarding the billing process.

2. Provider Payments

a) Waiver agencies process payment for all verified bills submitted by providers.

b) Waiver agencies make payments only for services authorized within the PCSP and delivered to the participant.

c) Waiver agencies submit MI Choice encounter data to CHAMPS electronically. Encounter data for MI Choice services meet CHAMPS requirements (including CHAMPS edits) for processing.

d) The CHAMPS system records encounter data detail.

e) Waiver agencies use MICIS, COMPASS, or compatible software to maintain an audit trail for funds expended.

f) MICIS, COMPASS, or compatible software produces claims detailing provider and participant identification, date of service, specific procedure, and payment data.

g) Waiver agencies have written procedures ensuring full payment to providers who furnish MI Choice services according to the authorized PCSP.

3. State Reimbursement to Waiver Agencies

a) The State reimburses waiver agencies based on the rates and conditions stated in the contract. MDHHS establishes and CMS approves capitation rates for MI Choice participants. The capitation payment is comprehensive and covers both administrative and service costs associated with each person enrolled in MI Choice.

b) The reimbursement structure includes an additional payment to cover Community Transition services provided to MDHHS-approved participants of the NFT program

who enroll in the MI Choice program upon transitioning to the community. The waiver agency must submit encounter data that includes at least one community transition service for CHAMPS to generate this one-time additional payment.

c) Capitation payments will be processed through reports generated in CHAMPS on a monthly basis. Payment to waiver agencies will occur through an electronic funds transfer on the fourth Wednesday of the month. This payment will be available to waiver agencies on the Thursday following the fourth Wednesday of the month.

d) Waiver agencies and providers accept Medicaid payment as payment in full for services rendered, unless the State makes an exception to this requirement. In addition, MDHHS requires waiver agencies to have policies and procedures to assure that waiver agencies and their providers do not seek or accept additional or supplemental payment from participants and their allies or representatives for MI Choice services.

V. FOLLOW-UP AND MONITORING

Follow-up and monitoring include contact between SCs, the participant or service providers to ensure providers deliver services as planned and to the satisfaction of the participant. SCs use follow-up and monitoring to evaluate the timeliness, appropriateness, and quality of services implemented under the PCSP. SCs monitor all services implemented on behalf of participants as a function of care planning and participant reassessment activities.

<u>Requirements</u>

1. SCs provide follow-up and monitoring to MI Choice participants. Waiver agencies maintain local policy and procedures assuring that participants have a continuous opportunity to provide feedback about services, supports, interventions, and treatments.
2. SCs contact participants at least every 30 days, unless otherwise specified by the participant, to monitor the participant's health and welfare, the provision of services (including verification of the delivery of one-time services), and the participant's

satisfaction with the current PCSP. SCs and participants can adjust services at this time to serve the participant better.

3. SCs contact newly enrolled participants within fourteen (14) days of the agreed upon service start date to verify the providers deliver services in the manner arranged and to the satisfaction of the participant. SCs may contact the service provider in addition to contacting the participant to verify the provision of services and any issues identified by the provider. This requirement does not apply to changed services or participants who are re-enrolling in the MI Choice program after a brief disenrollment period.
4. SCs and other waiver agency personnel document all follow-up and monitoring contacts in the participant case record.
5. SCs record changes in services negotiated during follow-up and monitoring on behalf of participants in the participant PCSP.
6. SCs provide oral or written feedback to providers regarding services furnished according to the PCSP when the SCs receive complaints from participants.
7. When SCs attempt to arrange a service that cannot start within 30 days, they must contact the provider agency every 30 days until a provider can implement the service.

VI. REASSESSMENT

Reassessment provides a scheduled, periodic in-person reexamination of participant functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the participant PCSP. Either an interdisciplinary SC team or an individual SC can perform reassessments. A team is not required to perform reassessments.

Requirements

1. SCs provide an in-person reassessment to program participants within 90 days of the initial assessment or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e. death of a primary caregiver).

2. SCs provide a subsequent in-person annual reassessment to participants or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e. death of a primary caregiver).
3. The reassessment is comprehensive and includes review of the same items evaluated during the previous assessment.
4. The SC may only copy and paste information that has not changed from a previous assessment to the new assessment when the information is still relevant.
5. The case record must reflect documentation that the participant continually meets the NFLOC. The record must indicate the appropriate door through which the participant meets the NFLOC criteria based upon the current assessment. If the SC does not complete a paper copy of the NFLOC determination tool, the corresponding iHC assessment data MUST support the door through which the SC indicates the participant meets NFLOC criteria.
6. The SC reviews reassessment findings with the participant. The SC and the participant update the PCSP, if necessary, based on mutually agreed upon service changes. The participant approves each service change. The SC sends appropriate notice to the participant and when necessary, obtains a clearly written signed statement from the participant that acknowledges the agreed upon change before service changes can be put into place.
7. When one SC completes an assessment, that SC should consult with an SC of the other discipline to assure all relevant issues have been updated and properly addressed.
8. When one SC completes an assessment and identifies participant issues that would be better addressed by the other discipline, OR when the other discipline reviewed the assessment completed by a single SC and identified additional issues, a SC from the other discipline shall:
   - **a)** Perform follow up with the first SC to assure the record properly addresses the issues, AND
   - **b)** When indicated by professional judgment as the best course of action, contact the participant to assure the issues are properly captured within the record and update the PCSP as needed, OR

- **c)** When indicated by professional judgment as the best course of action, conduct another in-person reassessment within the next 7 days to verify the first SCs findings and assure the record properly reflects and addresses all issues.
- **d)** a, b, and c above should be done in collaboration with the first SC and discussed with a supervisor.
- **e)** The SC includes reassessments in the participant case record.
- **f)** SCs instruct participants regarding how to contact SCs when needed for service and supports changes.
- **g)** Participants may refuse reassessment. SCs document this refusal in the case record. However, to maintain program eligibility, the waiver agency must assess all program participants on an annual basis.

9. MDHHS requires electronic data collection for all assessments completed for MI Choice participants. SCs must input all assessment data into an electronic system, such as COMPASS. The data system must record the date of and person responsible for any additional information put in the record or changes made to the original assessment data collected.

VII. RE-ENROLLMENT

A re-enrollment occurs when a previous MI Choice participant seeks enrollment in the MI Choice program again. This happens EVERY time the participant's status changes from Waiver/Yes to a non-waiver program, Waiver/Ineligible, Waiver/No, Waiver Financially Ineligible, or Closed and then back to Waiver/Yes.

Requirements:

1. The waiver agency must conduct the NFLOC determination according to the requirements set forth in the MI Choice chapter of the Medicaid Provider Manual for each re-enrollment, regardless of the reason for the original discharge or program termination.
2. The participant must meet all eligibility requirements for the MI Choice program.
3. A reassessment may be required before the waiver agency can re-enroll the participant. A reassessment is required if:

   a. The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
   b. The participant experienced a change in status. A change in status includes, but is not limited to a medical event (such as a heart attack, stroke, broken bone, or organ transplant) that changed the participant's functional ability, a change in the availability of the participant's informal supports, a noticeable change in the participant's cognitive ability, or a change in the participant's financial situation.
   c. The participant has been ineligible or otherwise out of the MI Choice program for more than one month, but remains an open participant with the agency.

4. SCs may perform assessments for a re-enrollment alone or using a RN/SW team. However, MDHHS requires an RN/SW team in the following situations:
   a. The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
   b. The participant experienced a change in status related to a decline in the participant's functional ability, informal support availability, or cognitive ability.
   c. The participant has been ineligible or otherwise out of the MI Choice program for at least 90 days.
   d. In emergency situations (i.e. when a reenrollment is to occur within the next 3 days) when the waiver agency cannot schedule a team reassessment, one SC may start the reassessment process to assure the participant meets MI Choice eligibility requirements and to develop a temporary PCSP. A SC of the other discipline shall complete the in-person reassessment within 7 days of the time the reassessment process began.

5. Waiver agencies should follow all other enrollment activities defined in Section VII: Enrollment, and perform the reassessments according to section XIII: Reassessment above.

VIII. CASE CLOSURE

A. Closed cases are those that SCs determine no longer require intervention. SCs document this status change in the case records. SCs designate closed case status for the following reasons:

1. Death, the SCs shall close the waiver case upon the death of the participant. The last date of waiver enrollment cannot exceed the date of death.
2. Moved, Transferred
3. Moved, Not Transferred
4. Not Eligible
5. NH (Nursing Home) Placement
6. Refused Service
7. ICF/IID Placement
8. Transferred to Another Waiver agency
9. Transferred to Another Agency
10. Moved to OSA CM
11. Moved to Waiver
12. Hearing
13. For Cause
14. Administrative
15. Other

Requirements

1. SCs document a reason for closure of a case in the participant case record.
2. The waiver agency must notify the participant or proxy in writing of the decision to close the waiver case 10 days before closure, unless an exception to the provision of advanced notice for an adverse benefit determination applies.

IX. CONFLICT RESOLUTION

A. SERVICE PROVIDERS

Conflict of professional judgment may arise during the development, implementation, and monitoring of the participant PCSP. SCs and service providers should resolve conflicts between themselves in a manner that promotes the implementation of the PCSP to the participant's satisfaction. If SCs and service providers cannot readily resolve a conflict through direct negotiation, SCs follow established waiver agency complaint procedures.

B. PARTICIPANTS

Participants have the right to work with a SC of their choice. SCs use direct negotiation to resolve conflicts between participants and the SC. If negotiation fails, refer participant/SC conflicts to the SC's supervisor for discussion and resolution through established procedures. If the conflict remains, participants may request assistance from an external advocate, including a supports broker. SCs or other waiver agency staff record conflicts not immediately resolved through negotiation in the participant case record. Participants maintain the right to file a grievance or internal appeal at all times, and the right to file a State Fair Hearing if the waiver agency does not act within established timeframes to address the grievance or internal appeal issue or if the participant disagrees with the decision rendered by the waiver agency on the grievance or internal appeal issue.

X. CASE RECORD REQUIREMENTS

Waiver agencies and their service providers maintain participant records, including assessments, plans of service, service or contact logs, reassessment, and quality assurance records for a period of not less than six years to support an audit trail. This includes maintenance of a Health Information System (HIS) that will collect, analyze, integrate, and report data as required within the MI Choice Contract and all attachments. The case record may exist in an electronic format. MDHHS does not require waiver agencies that maintain case information in electronic format to maintain hard copy case records. However, the waiver agency must make electronic case records available to MDHHS or other reviewers when conducting audits and other authorized reviews.

A. CASE RECORDS

Each enrolled MI Choice participant has an individual case record. The case record shall include, but is not limited to the following required information:

1. NFLOC determination results
2. Assessments and reassessments
3. Freedom of choice form, participant consent to enroll
4. Participant consents to release confidential information
5. Plans of service and service plans
6. Work orders and instructions to providers
7. Progress notes, contact logs or other notes that serve as a log in documenting pertinent contacts with participants, providers and others involved with furnishing services and supports to the participant
8. Any correspondence pertaining to the services and supports provided to a participant
9. Transfer and closure documentation

Requirements

1. Waiver agencies maintain MI Choice case records in a manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow up.
2. Writers enter hard copy case record information in ink.
3. Electronic Health Records (EHR) or Health Information Systems (HIS) (such as MICIS, COMPASS, HARMONY, or other systems for collecting case record documentation electronically) must have a method to lock records upon submission of data into the EHR that conforms to industry standards. The system must track all changes made to all information entered into the system including the date, time, and user making the change.
4. Waiver agency staff either signs or initials each entry in the case record. When using initials, the waiver agency maintains a signature log sheet with employees' names and initials. EHR shall record the user information for data entered in the case record.

5. Writers make corrections to case record entries by drawing a line through the incorrect information and entering corrected information above, below or adjacent to the previous entry. Whether written or electronic, under no circumstances shall information included in the case record be permanently erased. Electronic records shall include a method to correct information without erasing that information, such as using a strikethrough font. Additionally, electronic records shall include a backup system to retrieve any lost data due to system errors.
6. Writers identify late entries. MDHHS allows waiver agencies to make late entries in the case record as long as the writer notes that they made the entry sometime after the contact occurred. Writers may not enter previously omitted information as a late entry more than 7 days after the contact occurred (see how to amend a record below).
7. Writers may amend the record at any time by identifying an entry as a record amendment and describing previously omitted information. This type of entry should describe why the entry is being made (i.e. after peer or supervisory review) and who is making the amendment.
8. Writers may add entries to the record to correct earlier entries of electronic records that contained erroneous or inaccurate information.
9. Only the person that entered the original data into the EHR may edit that data. If this is not possible, other users may include a corrective note in the EHR that explains the error in the original data, but may not change the original data.
10. The system must date and time stamp all EHR entries and include the username under which the entry was made. The agency must keep a list of all usernames and the identification of the individual associated with that username.

B. PROVIDER CASE RECORDS

Waiver agencies assure that agreements with direct service providers contain the following minimum record keeping requirements. The participant case record includes:

1. Service work orders or authorizations.
2. Assessment, parts or all of the assessment provided by the waiver agency.

3. Types of services provided to each participant, i.e., a description of tasks completed by date of service, worker notes describing the tasks completed for each shift, and in-home service logs. Worker time sheets without tasks performed do not meet these criteria.
4. Ranges of time that each service is provided, i.e., 10:00 am – 12:00 pm; times are subject to change according to participant preferences and waiver agency authorization.
5. Date of service delivery.
6. Progress notes and supervisory notes.
7. Identification of the worker providing each service and that worker's signature.

Requirements

1. A worker service record (in home log) is a daily account of services furnished. The worker providing the service documents tasks accomplished each day. This log may be electronic as long as one is able to indicate all of the tasks performed during a shift. (Telephonic systems that record this information are considered electronic.)
2. Service workers maintain a record of services furnished by date of service, description of service provided on each date, and time of service provision each day.
3. Service provider agencies may not use worker time sheets as worker service records. Worker time sheets that do not include the tasks performed do not meet the requirement of worker service documentation.
4. Absence of a worker service record at a review for any date of service for which the provider makes a claim is equivalent to having no record that the service was rendered and could be subject to Medicaid recovery.
5. Service workers must sign each service entry. Electronic systems must include a method to identify the worker providing the information and rendering the service.
6. Counseling Records: Providers furnishing MI Choice counseling services maintain ongoing case records for each participant, recording assessed needs, treatment plan, and progress achieved at each counseling session.

C. WAIVER AGENT RECORDS

1. Waiver agencies maintain a copy of participant enrollment files to support capitated payments made through CHAMPS.
2. Waiver agencies maintain a record of payments made to providers.
3. Waiver agencies monitor contractors and subcontractor activity and maintain records and reports of the reviews and findings.
4. Waiver agencies maintain necessary records that disclose fully the extent of service provided to each participant for a period of six years for the purpose of subsequent audit.

XI. PROTECTING PARTICIPANT HEALTH AND WELFARE

Waiver agencies have policies and procedures consistent with this document to ensure the health and welfare of participants.

A. PARTICIPANT RIGHT TO APPEAL

Waiver agencies have written appeal processes consistent with MDHHS policy and 42 CFR 438. The participant has the right to request an appeal for any action, failure to act, or undue delay by the waiver agency. The participant initiates an appeal with the MDHHS Field Office when the participant disagrees with a financial eligibility determination. The participant initiates an appeal with the waiver agency when the participant disagrees with any other decision or action made by the program. Waiver agency staff may assist participants with filing the appropriate appeal documents.

Requirements

1. The waiver agency informs applicants and participants of their right to appeal.
2. Waiver agencies provide appeal rights to applicants and participants by sending an Adverse Benefit Determination to the individual
3. Waiver agencies follow time frames outlined in 42 CFR 438 and Attachment C of the waiver contract to hold hearing and render decisions.

4. If the waiver agency upholds the adverse benefit determination, the waiver agency informs the applicant or participant of their right to a State Fair Hearing.
5. The waiver agency presents the hearing summary and testifies on behalf of the Department at a State Fair Hearing for the MI Choice program.

B. MANDATORY REPORTING OF ABUSE, NEGLECT, AND EXPLOITATION

Federal Medicaid law directs waiver programs to monitor the health and welfare of all participants receiving waiver services. Additionally, MDHHS and waiver agencies must observe state statutes. Public Act 519 of 1982 (as amended) mandates that all human service providers and health care professionals make referrals to the AASA Adult Protective Services (APS) unit when the professional suspects or believes an adult is being abused, neglected, and/or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. The following requirements also apply for suspected financial abuse per the Financial Abuse Act (MI S.B. 378 of 1999).

Requirements

1. Waiver agencies maintain policy and procedures defining appropriate actions to take upon suspicion or determination of abuse, neglect, or exploitation.
2. Waiver agencies make referrals to the APS unit when they suspect abuse, neglect, or exploitation of a vulnerable adult. A vulnerable adult as defined in P.A. 519 is one who is unable to take action to protect oneself from harm.
3. Waiver agencies maintain policy and procedures that define how to follow up with APS to determine the result of the APS investigation and the next steps to take when results are unsatisfactory (e.g. chain of command, police, etc.)
4. The waiver agency documents suspected instances of abuse, neglect or exploitation and APS referral in the participant's case record.
5. The waiver agency assists the participant suspected of being abused, neglected or exploited by continuing to provide services and supports as needed.

C. CRITICAL INCIDENT MANAGEMENT SYSTEMS AND REPORTING

CMS requires a formal plan, developed and implemented by the state, to define, identify, investigate, and resolve incidents, events, or occurrences that jeopardize the health and welfare of a participant. States must address management of "critical events or incidents (e.g., abuse, neglect, and exploitation) that bring harm, or create potential harm to a waiver participant." The State's Quality Management Strategy must include the activities undertaken while the waiver program is in effect to systematically monitor critical incidents and reduce the potential for untoward events in the future through quality improvement.

1. Local Reporting System

a) Waiver agencies establish local reporting procedures for all complaints and critical incidences conveyed and detected by waiver agency staff, provider agencies, individual workers, independent supports brokers, participants, and their allies that jeopardize or potentially jeopardize the health and welfare of participants.

b) Waiver agencies maintain a system to log and track critical events. The system must include tracking the methods used to provide interventions, services, and supports to participants to resolve all known critical incidents that occur to the satisfaction of participants. Waiver agencies must also track the strategies implemented to prevent the recurrence of the abuse, neglect, or exploitation, to the extent possible.

2. Participant Reporting

a) Waiver agencies recount to MDHHS critical incidents reported by participants and their allies to waiver agency staff, and critical incidents brought to the attention of waiver agencies through any other means.

b) Waiver agencies must provide participants with information about how to report critical incidences and who to report incidents to, i.e., SCs, APS, and local law enforcement agencies.

c) Waiver agencies train participants and their allies how to identify and report suspected abuse, neglect, and exploitation including reporting incidents to APS and local law enforcement agencies. The training takes place through face-to-face interviews with participants during either PCP meetings, assessment visits, or

follow-up meetings. SCs conduct this training upon assessment, MI Choice enrollment, or PCP meetings, and annually thereafter. SCs may provide training more frequently when circumstances indicate that the participant needs it.

d) Waiver agencies inform participants and their allies that the law mandates SCs to report suspected incidents of abuse, neglect, or exploitation to the APS and MDHHS through incident management reports.

3. Waiver Agencies Report Critical Incidents to MDHHS

a) Waiver agencies submit critical incident reports to the MDHHS, MSA, Home and Community Based Services Section as they occur using the Critical Incident Management System. This system allows real-time access to critical incidents, as they occur, and as they are being resolved. MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within 2 business days of the waiver agency becoming aware of the incident.

b) Waiver agencies use the online Critical Incident Reporting System that allows automatic reporting of information as the waiver agency inputs the data.

c) Waiver agencies are responsible for tracking and responding to individual critical incidents using the critical incident management system.

d) Waiver agencies have first line responsibility for identifying, investigating, evaluating and follow up of the critical incidents that occur with participants as listed above.

e) Waiver agencies report to MDHHS all critical incidents including:

(1) A description of each incident;

(2) Investigations and strategies implemented to reduce, ameliorate, and prevent future incidents from occurring; and

(3) Follow-up activities conducted through the resolution of each incident.

f) Waiver agencies should begin to investigate and evaluate critical incidents with the participant within two business days of identification that an incident occurred.

g) Waiver agencies must report suspicious unexpected death that is also reported to law enforcement agencies to MDHHS contract managers as soon as reasonably possible, i.e., within two business days.

4. Types of Critical Incidents and Serious Events reported to MDHHS

a) Exploitation
b) Illegal activity in the home with potential to cause serious or major negative event
c) Neglect
d) Physical Abuse
e) Provider no shows for those participants who are bed bound all day or have a critical need for services as indicated by a 1A, 1B, or 1C service need level and no successful backup plan.
f) Sexual Abuse
g) Theft – of anything
h) Verbal Abuse
i) Worker consuming drugs and/or alcohol on the job
j) A suspicious or unexpected death that the waiver agency, or other entity, reports to law enforcement and that is related to providing services, supports, or care giving.
k) Hospitalization or emergency treatment resulting from a medication error.
l) Injuries requiring medical treatment.
m) Hospital and ER visits within 30 days of a previous hospitalization due to neglect or abuse.
n) Suicide attempts
o) Use of restraints, restrictive interventions, or seclusion.

5. MDHHS Responsibilities

a) MDHHS, MSA, Home and Community Based Services Section reviews, evaluates, and trends the incident reports**.**

b) MDHHS conducts an analysis of the strategies employed by waiver agencies in an attempt to reduce or ameliorate incidents from reoccurring to ensure the waiver agency took adequate precautions and preventative measures.

c) APS receives notifications of all suspected abuse, neglect, and exploitation and investigates as prescribed by law.

d) MDHHS provides training as needed to waiver agencies to educate staff on abuse and strengthen preventative interventions and strategies.

XII. MDHHS REVIEWS

A. CLINICAL QUALITY ASSURANCE REVIEWS

1. To meet CMS assurances and Medicaid PCSP authorization of services, MDHHS conducts record reviews and participant satisfaction interviews annually. The overall purpose of the MDHHS review is to determine, based on written case record documentation and discussion with waiver agencies, as needed, whether or not the waiver agency's authorized interventions protect each participant's health and welfare.
2. The MDHHS reviewer selects a random sample of each waiver agency's MI Choice participant records. MDHHS determines a statistically significant number of records to review based upon the total number of MI Choice slots used in a given fiscal year. The number of records reviewed at each agency is based upon the waiver agency's percentage of MI Choice slots multiplied by the number of cases MDHHS must review for statistical significance. The sample must include a minimum of ten records. There is no maximum number of records to review at each waiver agency. When reviewers find significant issues, concerns, or questions, the reviewer may request additional records for review and require additional investigation.
3. The MDHHS reviewer also conducts home visits from the participant records reviewed. The purpose of the home visits is to verify that what is contained in the record is consistent with what the reviewer observes in the home.

Requirements

1. 42 CFR 441.365 (b) defines the requirements of the assessment review team, including its composition and duties.
2. The CQAR review team consists of RNs with a minimum of a Bachelors Degree of Science and at least one other individual with health and social service credentials, which MDHHS defines as a licensed social worker.
3. MDHHS reviewers are trained in conducting PCSP, case record, and service authorization reviews.
4. Waiver agency clinical staff familiar with participant plans of service, service authorizations, and case record activity is available for discussion with reviewers, as necessary, during the review.

B. ADMINISTRATIVE AND FINANCIAL QUALITY ASSURANCE REVIEWS

MDHHS conducts on site reviews every two years to monitor waiver agency contract activities, billing, encounter data submission, and capitation payment processes to assure financial accountability and contract compliance with the CMS approved waiver plan, MDHHS policies, and contractual requirements. MDHHS also conducts on site reviews of waiver agencies and service providers to review participant case record keeping, provider qualifications, training records, and to interview staff.

XIII. WAIVER AGENT REVIEW REQUIREMENTS

A. QUALITY MANAGEMENT PLANS

Waiver agencies shall have a written quality management plan that meets requirements in the CMS-approved MI Choice application, 42 CFR 438 and the MDHHS quality management plan (as amended). The plan includes quality assurance and quality improvement using measurable goals and quality performance indicators. Waiver agencies include a description of the staff responsible for conducting quality assurance activities and their qualifications. MDHHS reviews the quality management plans annually. Waiver agencies report to MDHHS annually on their quality management plan activities and improvements.

B. WAIVER AGENT MONITORING OF SERVICE PROVIDERS

Waiver agencies conduct annual on-site monitoring reviews of enrolled recurrent service providers as stipulated in the MI Choice Program Provider Monitoring Plan.

XIV.ACRONYMS

AASA	The Aging and Adult Services Agency (formerly OSA)
APS	Adult Protective Services
AQAR	Administrative Quality Assurance Review
BEM	Bridges Eligibility Manual
Bridges	The MDHHS Field Office information system used for tracking Medicaid eligibility data
C&T report	CAPs and Triggers report
CAPs	Clinical Assessment Protocols
CFR	Code of Federal Regulation
CHAMPS	The Community Health Automated Medicaid Payment System, a successor to MMIS
CIM	The Center for Information Management
CIMS	Client Information Management System
CM	Care Management
CMS	Centers for Medicare and Medicaid, US Department of Health and Human Services
COMPASS	The successor to MICIS, a web-based information system for tracking participant data.
CQAR	Clinical Quality Assurance Reviews
DHS	The former Department of Human Services, now MDHHS Field Office
DME	Durable Medical Equipment
EHR	Electronic Health Record
FI	Fiscal Intermediary
HCBS/ED	Home and Community Based Services for the Elderly and Disabled
HHS	U.S. Department of Health and Human Services
HIS	Health Information System
HIPAA	Health Insurance Portability & Accountability Act
ICF/IDD	Intermediate Care Facility for Individuals with Developmental Disabilities
iHC	InterRAI - Home Care
LEP	Limited English Proficiencies
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
QHP	Medicaid Qualified Health Plan
MDCH	The former Michigan Department of Community Health
MDHHS	Michigan Department of Health and Human Services (MDCH and DHS combined)
MDRC	Michigan Disability Rights Coalition
MDS	Minimum Data Set
MDS-HC	Minimum Data Set for Home Care
MFP	Money Follows the Person
MICIS	MI Choice Information System
MIG	MI Choice Information Guidelines (the new TIG)
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MSA	Medical Services Administration
NFLOC	Nursing Facility Level of Care
NFT	Nursing Facility Transition
OSA	The former Michigan Office of Services to the Aging, now AASA
PACE	Program for All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PCP	Person Centered Plan/Planning
PCSP	Person Centered Service Plan

PDN	Private Duty Nursing
PDS	Physical Disability Services
PEM	Program Eligibility Manual (MDHHS Field Office)
PERS	Personal Emergency Response System
PET	Program Enrollment Type
PHI	Protected Health Information
QHP	Qualified Health Plan
QI	Quality Indicator
QMC	The MI Choice Person Focused Quality Management Collaboration or the Quality Management Collaboration.
RAI-HC	Resident Assessment Instrument for Home Care
RN	Registered Nurse
ROI	Release of Information
SC	Supports Coordination or Supports Coordinator
SCs	Supports Coordinators
SD in LTC	Self-Determination in Long Term Care
SMOU	Special Memorandum of Understanding
SW	Social Worker
TCM	Targeted Case Management
TIG	Telephone Information Guidelines
TIP	Temporarily Ineligible Participant
TPL	Third Party Liability